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# *The Clinique*

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A. K. CRAWFORD, M. D.





# THE CLINIQUE.

A MONTHLY ABSTRACT OF THE CLINICS AND OF THE PROCEEDINGS  
OF THE CLINICAL SOCIETY OF THE HAHNEMANN  
HOSPITAL OF CHICAGO,  
ETC., ETC.

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VOLUME IX, 1888.

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# THE CLINIQUE.

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VOL. IX.]

CHICAGO, JAN. 15, 1888.

[No. 1.

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## Original Lectures.

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### *INTUBATION OF THE LARYNX.*

FROM A LECTURE DELIVERED DECEMBER 22, 1887, BY G. F. SHEARS, M. D., ASSOCIATE PROFESSOR OF SURGERY.

Among the many questions upon which medical men have differed, no one has received more attention than the operative treatment of the croupous or diphtheritic stenosis of the larynx. Although authorities during the past few years have quite generally advised tracheotomy, there has been quite a decided difference of opinion as to the time an operation is justifiable. Some maintain that the operation should be made upon the first appearance of dyspnea, while others as strenuously insist that nothing but the most extreme symptoms can justify so severe an operation. This difference among authorities and, to say the least, the unflattering statistics of tracheotomy have led the general practitioner to hesitate in advising an operation in which the issue was so uncertain. The parents, in the early stages, naturally find it hard to believe so severe a measure is demanded, and at later stages it is of no avail. The operation of tracheotomy itself, although classed among the minor operations, is not in my opinion an easy matter. Many a doctor who can amputate a leg with neatness and dispatch is disconcerted if called upon to introduce a tracheal tube. The trachea is working up and down like the piston of an engine, the neck is swollen, the veins are enlarged, and the time is often at night. Take it altogether the disadvantages are many, and the results are

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not very encouraging. This in a few words is the status of the operation. When, then, Dr. O'Dwyer proposed to do away with all cutting operations, and substituted instead the insertion of a laryngeal tube by means of the natural passages, and supplemented this proposition with the report of a number of successful cases it will be readily understood that the proposition was received with enthusiasm, and rapidly put into practice so that although but a comparatively short time has elapsed since the first experiments were made the statistics now at hand seem to warrant the placing of the operation among the recognized surgical procedures.

To Dr. Joseph O'Dwyer, of New York, we are indebted for nearly all that now goes by the name of intubation of the larynx although, as is usually the case with all discoveries or inventions, it had been foreshadowed by the experiments of others. Fully twenty years before M. Bouchut of Paris had advocated the use of a laryngeal tube, and reported seven fatal cases in which he had inserted a hollow cylinder. The report was investigated by the Paris Academy of Medicine, and although dyspnœa had certainly been relieved the plan was declared impracticable and thereupon abandoned. To the American, therefore, belongs the credit of this new procedure in the treatment of laryngeal stenosis

The instruments demanded for the operation or the laryngeal tubes, the introducer, the extractor and the mouth gag. To these have been added the scale to determine the size of the tube demanded and by some operators a small rubber ring to act as an epiglottis. The tubes have varied much in shape and size. The one I present to you [see illustration,] is the form advocated by Dr. O'Dwyer, and the one most frequently employed. It is a gold-plated, oval tube, collared at the upper extremity, except at the anterior curve of the oval. The sides of the tube, compressed laterally, are made bulging and thickest midway, diminishing toward either end. The conformation of the head of the tube allows one angle to fit between the arytenoid cartilages, while the anterior portion is so beveled as to allow the epiglottis to shut down over the aperture. The bulging in the center of the tube holds it

more securely in place, and prevents its ejection during coughing. Each tube is designed to extend from the false cords to

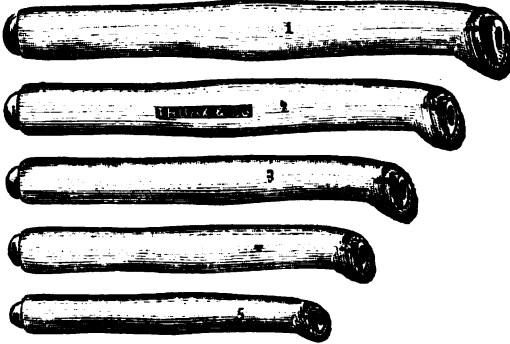


FIG. 1.

within three-quarters of an inch of the bifurcation of the trachea.

The introducer consists of the handle and the jointed intubator, which is firmly screwed into the handle. The intubator fits snugly into the tube, and holds it in place, ready for introduction. By means of a little spring in the handle the tube can be pushed off the intubator at the proper moment. [See illustration 2.]

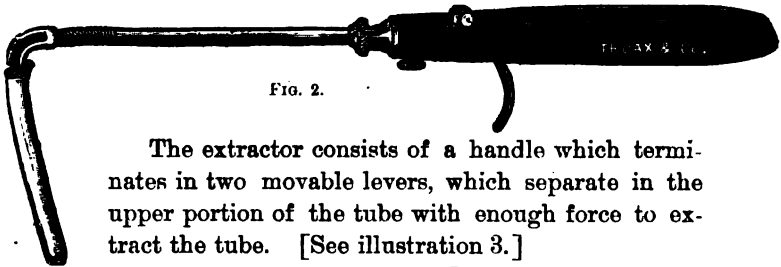


FIG. 2.

The extractor consists of a handle which terminates in two movable levers, which separate in the upper portion of the tube with enough force to extract the tube. [See illustration 3.]

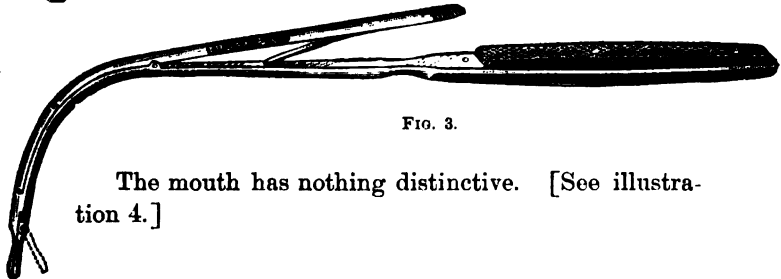


FIG. 3.

The mouth has nothing distinctive. [See illustration 4.]

The introduction of such a tube may seem to you easy enough. You will find upon practice that it is no simple matter.

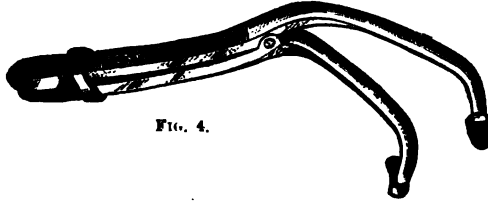


FIG. 4.

The journals contain many records of failures in the hands of skilled manipulators, and you may be assured that the failures not reported are more numerous than the recorded ones. I advise you to practice upon the cadaver, and when such opportunities are not at hand much experience may be gained by exploring the pharynx of children in health.

Having determined upon the operation, the first thing is the selection of the tube. It is a safe rule to select the largest size the age will admit, this being determined by the accompanying scale



FIG. 5.

Through the little hole in the tube a silk thread some sixteen inches in length is passed, the intubator screwed into the introducer and fitted into the tube. Now envelop the child in a blanket and place it in the nurse's lap. She should sit in a straight back chair, and hold the child upright, grasping it firmly by the arms, while an assistant stands behind and holds the head securely. The position of the child should be "as though hung from the top of its head." The gag is introduced into the left side of the mouth, well back between the jaws, and held by the assistant. The operator hooks the thread over his little finger, inserts the index finger of his left hand, elevates the epiglottis and directs the tube into the larynx. In introducing the tube be careful to keep the instrument in the median line. As the point of the instrument passes over the epiglottis the handle of the instrument is quickly elevated so that the tube may go down at right angles and not pass into

the œsophagus. As soon as the tube has passed into the larynx, the introducer is removed and the tube pressed into place by the finger. All those procedures must be done quickly. Respiration practically ceases from the time the finger is introduced until the operation is completed. It is much safer, therefore, to make several attempts than to persist for any length of time in a single endeavor. Entrance into the larynx is usually signalized by excessive coughing and improved respiration. After waiting a few moments to be assured of the position of the tube, the index finger is again pressed down upon the head of the tube to steady it while the thread is withdrawn. If the introduction of the tube is difficult, the extraction you can readily understand is equally so. The orifice of the tube is smaller even than that of the larynx, and is difficult to find.

The patient is held in the same position as during introduction, the left index finger finds the head of the tube and guides the jaws of the extractor into place. Firm pressure with the thumb is then made upon the lever above the handle while the tube is withdrawn.

*Case.*—The following case may be typical to you of many you may be called upon to treat. A short time ago I was notified by my friend Dr. Schmidt that he had a severe case of membranous croup, and asked to be in readiness to respond to a call for assistance. In a few hours the call came, and I hastened to the house. On the way I met the doctor, who gave me the brief history. The child had been taken several days before with croup. The disease responded readily to the remedies, and the child apparently recovered. The night before the child had a relapse, and by morning the doctor was alarmed. By noon I was sent for. There was no need for any discussion as the proper thing to do. The necessities of the case were apparent. The ears and lips were blue, the eyes bulged, and the whole appearance was that of almost complete suffocation. The respirations were slow, and at each attempt a most strenuous effort was made. The head was thrown back, the chin up, and the shoulders elevated. At each effort the bony walls were lifted up, and the intercostal and epigastric spaces retracted. It was evident to the most casual observer that the child had only a few moments to live unless air entered the lungs. The child was lifted from the

bed, wrapped in a blanket, and held by the doctor in the position recommended. The father held the head steady, and an assistant held the gag. In almost a shorter time than it takes to tell the story the tube was inserted, and after a brief period of coughing the child began to breathe regularly, the color changed, and the child was relieved. The gratitude of the parents you can imagine, and I must confess that when I thought of the accompaniments of tracheotomy I could not blame the parents for their great joy that the child did not have to be "cut." Before I left the house the child was asleep, and breathing as quietly as a child in health.

It is not every case in which the indications for the operation are so evident, neither should you wait until the child is exhausted or cyanosed. If there is suprasternal and epigastric retraction, if there is progressive dyspnoea, and a feeble or absent vesicular murmur at the posterior and inferior portions of the lungs the operation is demanded. Many times you may be in doubt as I was in the following:

*Case.*—I was called at 4 o'clock one morning by a brother practitioner to come to his assistance prepared to intubate. Considerable time was consumed in reaching the patient's house, which was at some distance. When I arrived the threatening symptoms had subsided and the little one was breathing quite regularly. The case did not seem to warrant intubation, and I did not insist upon it. Strict instructions were given to report any changes at once. Two days after I saw the doctor, and he made the following report: He had remained with the child a short time and then went home to breakfast. On his return he found the child asphyxiated, and before he could telephone for me the child was dead. I have always regretted having left the child without inserting the tube.

You have now the main points in the performance of the operation, but there are some little suggestions that may be of service to you. It is well to remember in cases of diphtheria that portions of the membrane during the violent struggle of the child may be coughed up into the face of the physician, and result in diphtheritic infection. It is well, therefore, for the operator to cover his mouth with his handkerchief or the antiseptic pad of Dr. Waxham. The finger should be protected by a rubber cot. Unless you have a careful assistant the gag is liable to be misplaced by the struggles

of the child. Under such circumstances the finger might be lacerated by the teeth of the child, a not to be desired accident in cases of diphtheria. It seems hardly necessary to caution one concerning traction upon the string, and yet one case has been reported in which while removing the mucus from the mouth the string was caught, the tube drawn out of the larynx and swallowed.

In another case the tube remained in the larynx, but the thread was swallowed, and had to be removed by fishing for it with a bent probe. A number of cases have been reported in which the tube has been swallowed. In one of the cases it was feared that the tube had descended into the trachea, and a tracheotomy was done. Several days afterward the tube was passed per rectum.

In none of these cases did any complication arise as the result of swallowing the tube. Most of the accidents occurred before the tubes were made bulging in the center.

The great objection to the operation is the difficulty of properly feeding the patient. The closure of the larynx is effected in health by the combined action of the constrictors of the larynx and the epiglottis. The former muscles are prevented from acting by the presence of the tube, and in many instances the epiglottis is prevented from closing the aperture by the head of the tube. It is evident, therefore, that deglutition will be accomplished with difficulty. Fluids especially are liable to get down into the larynx and excite violent paroxysms of coughing. Solids and semi-solids are swallowed much better and are to be preferred. In most instances it is best to refrain from all food or drinks for two or three hours after the insertion of the tube. If the child is hot and restless a little cracked ice may be held in the mouth. The first feeding should be done by the physician himself. A very good food is undiluted condensed milk. This being semi-solid, tenacious, easily passes over the tube without getting into the larynx. Other food, such as frozen milk, scrambled eggs, cornstarch, ice cream, thick soups and oat meal are readily taken after a time. In some cases fluids are taken with little difficulty, while in others no form of food is

tolerated, and nutrient enemias must be relied upon to support the patient. Dr. Waxham has made an effort to overcome the difficulty by decreasing the size of the head of the tube and placing around the tube a rubber collar with an artificial epiglottis attached. [See illustration 6.]



FIG. 6.

The collar projects sufficiently to prevent the tube from slipping into the larynx, and fits more closely than a metallic tube. When the child swallows the epiglottis presses the artificial epiglottis down over the aperture of the tube, and as deglutition ceases the natural elasticity of the rubber throws the artificial epiglottis upward. I have not had sufficient experience with the different forms to determine the relative value of this addition, but that it does not overcome this difficulty entirely has been shown to me in several cases. How long shall the tube be allowed to remain? This depends entirely upon circumstances. You may think it best to remove it within a few hours if breathing becomes embarrassed or the tube filled with thick mucus, and then re-insert it, or you may think it best to remove it once every twenty-four hours, and allow the patient to take food, if he can not swallow while the tube is in place. Where none of these complications arise the tube should be allowed to remain in for five or six days. You need not fear ulceration and injury to the voice as a result of long continued pressure. The head of the tube does not rest upon the vocal cords, but just above them; there is, therefore, no ulceration of the cords, and the little ulceration caused above is superficial and readily heals.

What is the value of the operation? This can not be determined by a single case or by a single opinion, but by a consideration of the combined experience of many operators, and under many circumstances. Of forty-eight cases operated upon by Dr. O'Dwyer there were twelve recoveries. Of 185 cases collected by me from the reports of different

observers, including my own, there were fifty-four recoveries or about 20 per cent. Of forty-seven cases collected and reported by Dr. Huber, twenty-nine were under three years of age, and among these there were eleven recoveries, the remaining eighteen were over three and under seven years, and of these there were nine recoveries. How do these results compare with those of tracheotomy. Of 466 operations in the Hospital des Enfants Malades during a period of eight years there were 126 recoveries, almost 25 per cent. In analyzing the cases that occurred during his service M. Andre says that while half the cases beyond six years recovered, not one-fourth of those under that age, and of six cases under two years not one recovered.

Of 325 operations made by American surgeons according to the monograph of J. Solis Cohens there were eighty-four recoveries or a little over 25 per cent. So far then as statistics of recovery are concerned, the balance is in favor of intubation. This is particularly true in the case of young children, for while in children of two years and under tracheotomy presents few recoveries, intubation reports almost 25 per cent. Briefly put, the advantages of intubation are: a greater percentage of recoveries; little difficulty in obtaining the consent of parents or friends; no necessity for chloroform or skilled assistants; no danger of the infection of a cut surface; little danger of pneumonia or bronchitis because the air larynx moist and warm, and finally it offers no obstacle to tracheotomy if the disease extends.



## Clinical Society Transactions.

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JOSEPH P. COBB, M. D., SECRETARY.

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The regular monthly meeting of the Clinical Society was held in Club Room No. 4, of the Grand Pacific Hotel, on Saturday evening, January 7.

In the absence of the president and vice-presidents, the meeting was called to order by the secretary.

Dr. H. B. Fellows was elected chairman, and presided until the arrival of Dr. J. D. Craig, vice-president, who occupied the chair the remainder of the evening.

Dr. M. C. Sturtevant, of Morris, Ill., was proposed for membership by Dr. H. B. Fellows.

Drs. E. B. Cole and J. H. Schmidt were elected to membership.

The Bureau of Ophthalmology and Otology, Dr. C. H. Vilas, chairman, offered the following report:

A REVIEW.—By C. H. VILAS, M. D.—I propose to-night to report on some of the more recent advancements in the art of ophthalmology and otology as gleaned from practice, and shall limit myself to those phases most interesting and useful, as I deem them, to the general profession. Time does not permit of a thorough review, and as many devote themselves to the discussion of internal remedies, I intend to incidentally confine myself for the most part to local measures and expedients. For this course I offer no apology except the shortness of time at my disposal, rendering it impossible to well treat of both, and I shall not discuss the question of the curability of eye and ear disease by internal remedies alone, because I am of the opinion that those who depend on internal medications alone will never cure all cases which might be cured were they treated with all the means at our command. While startling isolated cases of alleged cures by any method may interest our attention, test our credulity,

or excite our admiration, they should not lead us to cease well-doing and study, for routine methods of any kind lead not up to the highest triumphs of the medical art, but rather tend to blunt our perceptions and dull our senses to the results of the evolution on every hand awaiting our recognition.

The transplantation of animal eyes has been fully advertised in the secular press, and apochryphal cases have been freely bandied about. Could we believe all one reads, the triumph of surgery would indeed be great. But truth records no case of success yet. On several occasions a tentative success has been met with, and eyes have adhered, and a union taken place between the conjunctiva and sclera sufficient to cause an adhesion to the contents of the orbit. In all cases, however, the integrity of the globe has given way, and the eye been voluntarily removed, or the hand of the operator has been invoked. Prodromal sympathetic symptoms in the companion eye have warned of dangers not disclosed, and the operation has been abandoned.

The questions of asepsis and antiseptis continue to call forth warm disputes. While with many operations of perhaps less value in its results than with others, I am of the opinion that the majority greatly profit by the precautions incidental to the practice of sterilization. Frequent washings of the vagina during parturition will not remove post-partum causes of ophthalmia neonatorum and hence not obliterate the disease, but to limit the ante-partem causes, it must be of value. With the other questions involved in asepsis and antiseptis of the puerpural toilet, I shall not concern myself, further than to remark that properly carried out no harm can, and much good may, result.

As regards the prevention of infection of the wound in corneal incisions for cataract, the necessity for such precautions much depends on the habits of the operator. As no one would now cut the cornea of an eye with a declared muccecele, so no one who has the welfare of his patient at heart would risk the corneal contact of an infected knife, or one exposed to the danger of infection. As chairman of the Bureau of Ophthalmology and Otology of the American Institute of Homœo-

opathy the past year, I reported some experiments of my own without the precaution of asepsis, and in my own case I believe with as good results as would be obtained with full sterilization. But such successful experience may fall to few operators, and we all should be jealous of our patient's welfare. Each one must be a law unto himself, and so long as his success is unimpeachable, he may or may not adopt such measures, which also must depend on the surroundings, and the dangers incident to the exposure of the patient and the operator's person, and the climatic influence. Nothing is too trivial to consider which affects the result of an operation on such an important organ. For such sterilization the bichloride of mercury continues to hold the first place, and a solution of 1:2500 or 1:5000 is the usual strength.

Continuing this subject, I intend to speak regarding its application to otorrhœa. While not strictly in the line of curing (as I deem a cure) ear discharges, I feel, with all due deference to internal treatment, that the subject merits attention here, for constantly new local remedies are proposed. While I believe and have always taught that it is not desirable, proper or necessary, and often highly dangerous, to primarily stop ear or any other discharges, or even to attempt to do so, by local means, certain cases sometimes linger under internal remedies alone until the patience of both patient and physician is sorely taxed. An adjuvant may be expedient to allay the local irritation, or to deodorize, and for such an one none is found better than the boracic acid ground to an impalpable powder. This may be applied by means of an insufflator through the external auditory meatus, great care being taken to touch each spot with the remedy. I am satisfied that, internal remedies having been faithfully tried, one cause of failure to cure the last dribbling remains of an ear discharge by boracic acid is due to each spot not being fully touched.

I hope no one will attempt to interpret these directions as any excuse for the damming up of a discharge, or even its suppression by local remedies, or will attempt primarily to cure a well-established ear discharge in this manner; and,

while on this subject, I may say that it is often easy to hold up a discharge by internal remedies as effectually as by local ones, as any one conversant with the powers of such remedies as *Tellurium*, *Pulsatilla*, etc., well knows; and ignorance or carelessness may be as well disclosed by internal trifling with common remedies as by external or local applications. Danger and delay, if nothing worse, are often brought about by the former course, and no one has been excusable for the last twenty years for failure to appreciate this.

Peroxide of hydrogen is also valuable, especially in cleansing a surface contaminated by pus. It may be used to remove and cleanse otorrhoeic discharges, but as a curative agent is not the equal of or as generally applicable as boracic acid.

The after treatment of cataract operations has undergone many modifications, and most operators now are less careful to exclude light in certain cases than formerly. I have for years pursued the Vienna system of bandaging, and the careful examination of the eyes only by well-moderated artificial light. When at the Royal Ophthalmic Hospital, Moorfields, London, I was impressed with the apparent lack of care in this respect, only to afterward become a partial convert. Accidentally light was admitted to one of my cases, and I found the patient lying without a bandage, and exposed to full sun-light. A good result following, with a much-diminished period of convalescence, I was led to reflect, and cautiously experiment. About this time the reported experience of several good and careful oculists so closely tallied with my own that I have since, in such cases as seemed adapted to such a course, permitted a freer admission of light, even to placing patients in the full rays of the sun.

Any one who will carefully study the shape of the tarsal cartilage will see that it is well adapted to act as a splint for the holding of the corneal flap in place, and may easily be used for such a purpose. This is easily accomplished by fastening the upper lid down by a strip of adhesive plaster, gently and carefully applied. The case may then be allowed to go on to recovery.

In my report alluded to before I reported on the new process of treating the non-suppurative proliferous form of aural catarrh by "massage of the ossicles." The famous proof-reader so long in the service of our national society, allowed me to escape by making it read "massage of the auricles;" a less happy result than fell to the lot of some of my fellow-sufferers. I would again refer to this method of treating these cases, and summarize by saying that well done, by carefully prepared probangs, I am of the opinion that a moderate success is shown. Anything that will relieve even a few of these generally hopeless cases must be accepted as a boon.

Finally, as evidence of the different composition of minds, it is interesting to note that not even the natural secretions of the body are allowed to escape the terrible scrutiny of the microbe hunter, and the pleasures of the chase are incited by the wild halloo of the enthusiast who discovers the most horrible causes of infection of corneal wounds by the normal tears. But beyond the pursuit of these newly discovered and diverting biozoids nothing has been accomplished, and until demonstration succeeds declaration, I think we may safely look elsewhere for the cause of such infection as worries and injures our corneal wounds.

**SYMPTOMS PRODUCED FROM POLYPOID GROWTHS IN THE EAR.—**

By DR. JOSEPH WATRY.—Polypi in the ear are almost always the result of a neglected case of suppuration of the middle ear. They are most frequently found to take their origin in the tympanic cavity. Sometimes they are found to have their seat in the external auditory canal close to the tympanum. They appear as small nodules upon the walls of the middle ear, and may develop from the size of a pin-head so as to fill the cavity and project into the auditory canal. These growths according to their structure may be divided into three classes:

I. Mucous polypi should be mentioned first, because they occur the most frequent. Next in frequency are the fibromata, and third the myxomata, which are seen only in exceptional cases.

According to Prof. Billroth, of Vienna, the mucous polypi consist of a delicate but loose stroma of connective tissue, containing numerous blood-vessels and mucous fluid. During the process of their formation, some of the blood-vessels may become obliterated, and the growths assume a firmer and denser character, thus developing into the fibromata.

The mucous polypi resemble very much the surface of a raspberry; they are generally red, with granular projections. Their attachment to the mucous membrane is frequently pedunculated, but is also found to have a broad base.

II. The *fibromata*, much paler and smoother than the variety just described, consist of dense fibrous stroma, while the myxomata are of a gelatinous character.

III. As soon as *granulations* spring up in a suppurating ear, new fuel is added in maintaining the original disease, and the discharge can only be stopped by their removal. When the polypi are small they cause little or no inconvenience, nor is their presence commonly detected by those who are not accustomed of examining the ear, except by the most careful inspection. The most frequent, yet not the most prominent symptom, is a profuse, offensive discharge which may from time to time be mixed with more or less blood, especially if the growths are of the mucous variety. As they increase, a sensation of fullness and dullness of hearing is observed, followed by a singing and hissing noise in the ear. Not unfrequently there is a sense of heaviness, giddiness and confusion in the head, with fainting spells and nausea. If the growths have attained a considerable size, these symptoms become very marked, and sometimes fatal consequences may result by obstructing the passages and thus cause retention of the purulent secretion, which may cause extension of the purulent inflammation to the walls of the tympanic cavity or to the large blood-vessels running along and piercing the surrounding partitions.

In exceptional cases their formation is attended with considerable pain. This is especially apt to be the case if the tumors are hard and unyielding, so as to cause pressure upon the numerous nerve-filaments which surround them.

Unfortunately, however, in the majority of cases, the polypi cause no prominent and urging symptoms, and hence they are tolerated by the patients who slightly estimate the trouble to be only a "running ear."

Thus they are allowed to keep up a constant irritation, and often seriously impair the patient's health, which would not be the case if the symptoms were somewhat alarming to the patients when the polypi first begin to take root.

The following cases clearly demonstrate how patients are liable to complain when polypoid growths exist in the ear:

*Case I.* Mr. B., thirty-five years old, strong and healthy, had pain in his right ear two years ago. The pain continued for about one week, after which a profuse discharge of matter took place, and has had no pain since. The discharge, however, never ceased, although the ear was washed and wiped out frequently. At times he has had a sense of fullness with noises in the ear. Lately he observed that the discharge is very offensive and had two bleedings from the ear, which alarmed him very much. The hearing began to fail very rapidly a short time ago, and can now hear, only with difficulty, the tick of a large clock when the ear is held close to it. After the interior of the ear had been thoroughly cleansed, it was examined by means of the reflector and speculum. The drum-head was totally destroyed, and a growth about the size of a hazel-nut occupied the tympanic cavity. Its surface was very red, and the slightest pressure upon it with the probe caused it to bleed, but the patient experienced no pain, nor any uncomfortable feeling.

On passing the probe around the little tumor, it was found to be attached by a small pedicle to the upper portion of the outer wall of the labyrinth. The diagnosis was that of a mucous polypi and the next step was to remove it. As the tumor was of the mucous variety, and attached to a small pedicle, its removal with the snare was decided upon.

The snare used is a modification of Wilde's.

It consists of a perforated tube about two and one-half inches long, and a square bar about two inches in length. To the outer end of the bar is attached an oval ring, for the reception of the thumb; on the inner end of the bar is an opening with a stop-screw in which the tube is placed and fastened.

When fastened together they form an obtuse angle to each other. On the square bar is a slide with a small projecting pin on the upper, and a ring to receive the index finger

on the lower surface of the slide. The wire passes through the perforated stem, and a loop of the size desired is then formed by drawing down the ends of the wire and fastening them to the projecting pin on the slide. The tympanic cavity having been well illuminated, the length of the polypus and the position of its attachment ascertained. The snare held by means of the thumb and the index finger, and the wire loop bent at the desired angle to the stem of the instrument was made to encircle the growth by a kind of rotary movement, without exciting much pain. The movable ring was then firmly pulled down toward the thumb, and the growth was constricted and completely divided. The bleeding was very soon controlled. On re-examining, a small elevation in the upper corner of the cavity was discovered, which might have been easily mistaken for the hypertrophied tissue; but the passing of the probe around it proved it to be a very minute polypus. This was removed with a sharp curette.

The roots were touched with *Argentum Nitricum*. Prescribed *Per-oxide of hydrogen* to be poured into the ear twice a day. A week later the patient reported that there had been no discharge for a few days. Continued the same treatment for another week, after which the patient was discharged with a hearing power of twelve inches for the tick of a watch which should be heard at thirty-six inches by a normal ear.

*Case 2.*—July 7, a man thirty-eight years of age, of more than average intelligence, carpenter by trade, gave the following history:

“When a small boy my right ear used to gather and break several times each year. The discharge never lasted over two weeks. While the ear was discharging, I always used to have a fullness and cracking noises in it, which generally continued several weeks after the ear stopped discharging. When I grew older I at one time went two years without having any trouble. Two years ago, after having taken a severe cold, the ear gathered again, and has been discharging ever since. The hearing has been failing gradually. The fullness and noises in the ear became very marked.”

Here the patient was asked about the general health, and he continued: “My health has always been very good with the exception of taking cold easily. About a year ago my health began to fail, somewhat; I began to have a great deal of dull, heavy, aching pain in my head, my appetite became poor, and I often would feel sick at the stomach. Some time ago I went to see a doctor who gave me medicine, but it did no good. Instead of improving, I grew gradually worse.



Six weeks ago I began to feel dizzy, and to have pain in my eyes. Three weeks ago I had to give up working on account of the severe dizziness. I feel, when walking, like a drunken person, and when standing and observing people passing by they appear to stagger."

What seemed most surprising to him was, that he was not able to draw a straight line even with the aid of a rule, not that he could not place the rule correct, but an inability to draw the pencil along the side of it; before reaching the end the pencil would rest about three inches from the rule.

Whenever he laid on his right side, the symptoms became ameliorated but very much aggravated when turning on the opposite side. The examiner took hold of the auricle, and widened the meatus by pressing the tragus outward. A large smooth-surfaced and waxy-looking growth was plainly seen about midway in the canal. The probe could easily be passed around the tumor until it reached the cavity of the tympanum.

Here the growth presented a broad irregular attachment, and felt firm and hard to the touch. Pressure on the growth with the probe brought on severe dizziness with flashes of light, followed by impairment of sight. It took about two minutes before the symptoms passed off. If the tumor was pulled upon right after the pressure, the symptoms disappeared almost suddenly, and the patient exclaimed, "That makes me feel like a different man."

As the growth, in this case, was chiefly of fibrous structure, and of an unusual hard texture. The snare did not answer the purpose, because the thin wire lacked sufficient strength, while wire of greater thickness would have failed to penetrate the tumor. The instrument, therefore, employed was a pair of narrow bladed and curved scissors. With them the polypus was cut out as far as possible. After the hemorrhage was stopped the remaining portion (about one-half) was punctured a number of times with a narrow bladed cataract knife followed by an application of a twenty-grain solution of *Argentum nitricum*. This was repeated twice a week. The patient was instructed to syringe out his ear twice a day, to dry it, and pour in from ten to fifteen drops of rectified spirit of wine, one part of the medicine to three parts of water.

After a month's treatment the staggering gait had almost entirely disappeared, and the dizziness was very much less. He could not draw a straight line. The same treatment was continued, and on September 22 the patient remarked: "I am feeling well. Would not know that there is anything the

matter with my ear, only for the discharge and a stuffed-up feeling." As the growth was now almost destroyed, only an eight-grain solution of the *Argentum nitricum* was used. October 18 the tumor was destroyed and not a trace of the above-mentioned symptoms was present. There was, however, a slight discharge for some time, which yielded to local and internal treatment.

TEA AS A HEART-IRRITANT.—H. P. HOLMES, M. D., SYCAMORE, ILL.—I wish to give my experience in the use of tea as a beverage acting as a heart irritant and as a complication in the treatment of functional heart troubles.

For some time previous to my first course of lectures at Hahnemann College I had been troubled with symptoms which led me to fear heart disease. These troubles were mainly at night, and came in the form of repeated nightmare from which I would wake more or less frightened to find the heart beating very slowly, heavily, and at times with a force sufficient to shake the whole body. The pulse at these times was often as low as in the forties, and on one occasion I counted it at thirty-six immediately on waking, and with no other movement than to quietly take my watch from under my pillow. Medical treatment from home physicians only modified the trouble without effecting a cure. So, as opportunity offered, I consulted Prof. Fellows. The most careful examination revealed no heart lesion and I received the encouragement that it was only a nervous affection which would pass off when I had left the lecture room and would have more out-door life. Remedies again produced no effect. Thinking my trouble might be due to smoking, I gave up the use of tobacco for a year; but instead of being benefited my trouble grew worse continually. During the summer intervening between my two courses of lectures I suffered, during the nights, all the horrors of Dante's *Inferno*. Almost invariably a horrible nightmare came to me on first going to sleep. These were especially aggravated by sleeping on the left side, the side on which I had always slept the best. These visions took the form of robbers, murderers, ghosts, wild animals and countless snakes. All seemed bent on doing me some bodily injury, but I always woke in a terrible fright just as they were about to effect their purpose. At other times I would find myself falling and would wake with the life well nigh scared out of me. Matters got so bad that I dreaded to go to sleep and often sat up until the small hours to shorten my night of torture. During the day there was

frequent intermitting of the pulse, and frequently the intermitting beat was accompanied by an involuntary cough.

In this condition I entered upon my second course of lectures, expecting, as a son of Erin would say, to wake up most any morning and find myself dead. I again passed under the examination of our professor, and was again assured that the trouble was only a nervous one. Two or three more remedies were tried without effect.

One evening at supper, a fellow student incidentally remarked that he could not drink tea as it gave him palpitation of the heart. I was inclined to doubt his statement, but he assured me that he had tried it repeatedly; whenever he had drunk tea for any length of time he was troubled with palpitation of the heart, and it always left him on giving up that beverage. This set me thinking; I saw that my whole trouble had been coming on since commencing to drink tea when eighteen years of age. I stopped drinking tea that night, and took no more medicine for my trouble. To my great surprise and greater delight I was wholly cured in two weeks. No more palpitation, no more nightmare, no more dread of going to sleep, and I could sleep on my left side as well as on my right. Since then I have tried the tea-drinking many times, and invariably find that one cup of tea at night for three or four nights in succession will bring on dreams too horrible to make life worth living. As far as I can determine the different kinds of tea make no difference in the results.

Since then I have applied the knowledge gained from these experiences to my treatment of heart troubles. Where no organic lesion can be detected, and where close questioning brings out these four points: heart trouble, bad dreams, dreams worse while lying on left side, tea drinker, I have found marked relief to follow the strict avoidance of tea. I will relate two cases from practice which will serve to show the results obtained.

*Case 1.*—A merchant had supposed himself in a hopeless condition from heart disease; was examined some years ago by Dr. Hale, whose diagnosis, I believe, was no organic lesion but the trouble seemed due to a loss of nerve force, and that organic lesion would very likely follow if the trouble was not corrected. My patient was in a very anxious frame of mind, and told me if I found his heart in a bad shape he rather hoped I would lie about it. I could detect no organic lesion by the most careful examination, nothing but the irregular, unsteady, nervous action. I asked him about tea drinking, and found him to be not only a tea drinker, but a man who

prided himself on being a judge of the article, and a great lover of the beverage. Still he was willing to give up the use of tea if I thought best. One or two prescriptions which I think had very little to do with the case and the strict avoidance of tea put him in a better condition than he had been in for years. A year afterward he came to me with the same old trouble. My first question was in regard to the tea drinking. He laughed and plead guilty, saying his friends had persuaded him to drink it as they did not believe it would hurt him. His reformation was followed by immediate improvement. Since then he has had two relapses from the same cause and each time improved on giving up the use of tea.

*Case 2.*—The other case is a patient from Boston who was examined by a physician there and also in New York for supposed heart trouble. No organic lesion could be detected, and no improvement followed the treatment in either case. He incidentally or accidentally came to me and told his story. He loved tea better than tobacco or whisky although he used all three *ad libitum*. He drank a great deal of tea, often three or four cups before retiring. Bad dreams, an irregular pulse and oppressed breathing. No medicine at all and giving up the use of tea corrected his whole trouble in a very short time.

These are but two cases cited from several years of experience, and are samples of the good results following this kind of treatment. My object in presenting this paper is to bring the question before you as I have never seen any literature upon this subject. It is a question in my mind if tea does not have a great deal to do with many cases of heart disease, and I am certain that it is a serious complication arising in the treatment of heart diseases.

Since first writing this article I have found the following symptoms under the divisions "Heart" and "Sleep" in the pathogenesis of *Thea* in Allen's Encyclopædia. Heart's action—heart sometimes palpitated and other times seemed motionless. Palpitation—palpitation of the heart at night with inability to lie on the left side. Palpitation of the heart: on examination, I generally find dilation with thinning of the heart. In the worst cases that are on record, the fluttering of the heart has been succeeded by a momentary suspension of its action and long continued swoonings. Pulse in some cases weak and slow, in others fluttering or intermitting. Sleep—sits up late at night because she cannot sleep, and often lies awake until morning: troubled dreams, waking at

intervals; awoke suddenly as from a struggle of incubus. The ordinary effect of green tea taken late at night is incubus or nightmare in its most formidable shape; and many persons who, after a hearty dinner, have taken green tea, wake in the midst of the night in a state of most fearful agitation and excitement; the head is oppressed, a sensation of approaching death is felt, or sometimes the person seems to be dragged from the lowest abyss of darkness back to the world, from which, during his paroxysm, he had felt himself gradually to sink. Horrible dreams, etc.

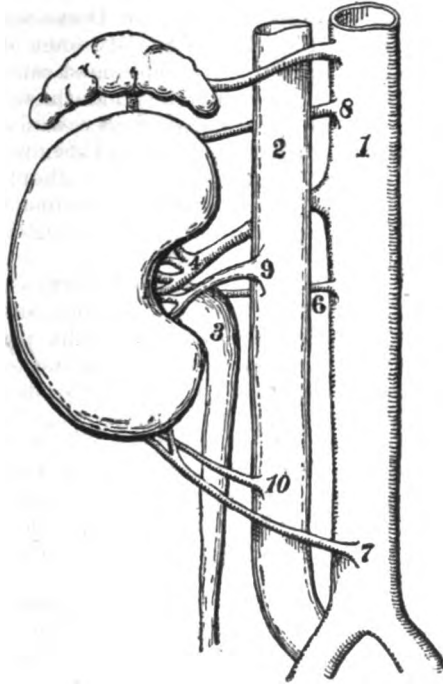
ABNORMALITIES OF THE ARTERIAL SUPPLY TO THE KIDNEY.—By DR. O. M. BAIRD.—Although abnormalities of the renal arteries are not very rare, the following case is worthy of record. Upon opening the abdominal cavity of a large and powerful male "subject," I found the viscera normal. The two kidneys were properly situated, and the left one was as it should be, but the right one showed a deviation from the normal type. The right renal artery was of the usual size, dividing into two branches before entering the hilum of the kidney. An artery the size of a small goose-quill, given off from the anterior surface of the abdominal aorta, one-half inch above its bifurcation, was of most interest. It was about three and a half inches in length, passing upward, outward and backward, entering the kidney at the inner and inferior angle, dividing into two branches half an inch before its termination.

Entering the inner superior angle of the kidney another artery was found, about half the size of the former. It was given off from the side of the aorta opposite the superior mesenteric artery.

Still another artery, and which might properly be called a true renal artery, was found entering the hilum between the two branches of the renal vein. This was half the size of the renal artery proper, and given off from the aorta one half inch below it. The accompanying diagram shows the exact relation of the vessels as we found them.

Henle says that similar cases of renal abnormalities are found in one out of five or six cases. Dr. Bruce Clarke thinks that about one in thirty cases would be nearer right. Such

cases are of practical interest to the surgeon only, and should be remembered in making an operation for the removal of the kidney.



Since noting the above case we have found two other cases of abnormalities in the renal artery supply, one in which both kidneys received a small arterial twig into the superior angle.

The last case observed was very like the first one. In it the abnormal artery was at least two-thirds the size of the renal artery proper, and came off from the abdominal aorta a half inch above its bifurcation on its anterior surface, and entered the right kidney at its inner and inferior angle.

Our observations as demonstrator of anatomy would warrant us in saying that abnormalities in the blood supply of the kidney occur in about one in every ten cases.

DORSO-SCAPULAR NEURALGIA.—By DR. C. E. LANING.—Having been much interested in reading the cases reported in the November issue of THE CLINIQUE, by Dr. T. G. Comstock, of St. Louis, and having had a case in many respects similar to the one entitled “Hidden Seizure or Dorso-scapular Neuralgia,” I will give to the Clinical Society some of its principal points. Some time in 1885 a gentleman came to me who was and who had been for a number of months suffering from some disease which the various physicians consulted could not diagnosticate. He had had the opinion and been under the care of some of the best old school physicians without their either being able to arrive at any satisfactory conclusion as to the cause of the pain, or to relieve it in the least, except by the use of morphine, as in Dr. Comstock’s case.

The patient a man of thirty-seven or thirty-eight years of age, was of medium height, and of a nervous, sanguine temperament. He had lost considerable weight, principally for the reason that the pain and the morphine together had almost entirely destroyed his appetite and digestion. He complained of pain varying in character from a dull ache to most excruciating, cutting, tearing pains, confined to the interscapular region, when of the former kind and extending down one or both arms, down the back and around into the pectoral region when most severe. Being a man of strong will, and opposed to the use of opiates, he had suffered much sooner than resort to them for relief, lying awake at times night after night until so thoroughly exhausted as to be obliged to seek rest through the use of morphia.

I made a very careful examination of the patient and was unable to detect any lesion which, in my judgment, could possibly give rise to the pains from which he suffered. On account of the point of origin of the pain (interscapular), there being no spinal nor infra-diaphragmatic lesion, nor evidence of œsophageal or mediastinal disease, I by exclusion diagnosticated an aneurism of either the arch of the aorta or of some of the branches of the pulmonary artery.

In studying the case from a therapeutic standpoint, I could find no remedy so well indicated as *Aconite*, not so especially as regarded the pains, but the mental symptoms and condition pointed unerringly to that remedy. The patient had almost all the time an anxious, worried, nervous look, which became more marked as the pains increased; he was afraid of a crowd, or to cross the street if any horses or vehicles were in sight, in short he presented a complete mental picture of *aconite*, and in the hope of relieving this condition, which he assured me was fully as hard to bear as

the physical suffering, I gave that remedy in the third dilution on cones, two cones from three or four times a day to every fifteen minutes, when the paroxysms were at their height. Under this remedy the mental phenomena mentioned almost entirely disappeared, and the pains diminished in severity to such an extent that he felt no more need of morphine. The tendency to more or less regular and decided exacerbations still continued, though at the worst they were not to be compared in severity to his former attacks, while at certain periods of the day he was almost entirely free from all discomforts. As a result of his discontinuing the use of morphine, together with the relief from pain, his appetite and sleep returned, and he began to gain in weight. About this time a party of his friends having planned for a southern trip he concluded to accompany them, and accordingly went to Florida. He stood the trip very well, and even gained in all respects so far as he could judge. Feeling so well, he one day was tempted to join in a hunting excursion and as a result of exposure to the sun, combined with the fatigue incident to the trip, he was taken with all his old symptoms, and his companions started home with him. During the journey, under the influence of the *Aconite* which he had taken with him, but which he had neglected to use for some time, he once more was apparently as well as before the last attack. I had warned him very thoroughly against any physical exertion, as well as cautioned him in regard to any mental emotion or indulging in coitus. The train having stopped at a pleasant little southern station for half an hour, he with some of his friends, got off, and some of the number started a jumping match in which he soon joined in spite of remonstrances of his friends, and their reminders of what the Doctor had told him. He insisted on showing his agility, saying that he didn't believe anything much was the matter with him, and that the Doctor had only tried to frighten him. He actually made one leap which excelled any made by his friends, and was immediately picked up in what was supposed to be a dying condition. Strange to relate he once more rallied, and in due time arrived in Chicago. He drove home and instead of allowing himself to be helped out of the carriage and up the steps, he jumped out and ran up to meet his wife who had come to the door and who called to him to be careful. He ran lightly up the steps and greeted her, and the next moment fell to the floor and expired instantly.

For some time previous to his death I had begun to doubt the correctness of my diagnosis on account of the very decided benefit he had derived from the use of the *Aconite*,



reasoning, that if there was an aneurism and the pains were due to it, that it would be impossible for the remedy to produce the effect which it repeatedly did. Being out of the city at the time of his death, I knew nothing of it nor of the *post-mortem* which had been made by several of the old school physicians who had formerly attended him, all anxious to ascertain the cause of his suffering and death, and at the same time demonstrate that I had made a mistake in diagnosing an aneurism. They found dilatation of the right heart and a large aneurism of the left trunk of the pulmonary artery, which had caused death by its rupture. They made no examination of the cord as they concluded, justly, I think, that all the spinal symptoms were purely reflex in character, and due to the aneurism.

So far as my experience goes, pains of the nature and in the location of those which existed in Dr. Comstock's case, and the one just reported, are in the great majority of instances due to an aneurism within the thoracic cavity. Cancerous or malignant disease of the upper or middle portions of the œsophagus comes next in frequency. A dull, more or less constant ache in the spine in the interscapular region, an ache which seldom or never develops into an acute pain or radiates outward, is in a large number of cases a reflex from some of the abdominal viscera, most frequently the stomach; the reflexes from the liver or spleen for some unaccountable reason almost invariably passing up the splanchnics, and then along the filaments of the sympathetic which join the intercostal nerves, the pain in such cases being located at the inferior angle of the right or left scapula as the case may be.

“LUDLAM'S DISEASES OF WOMEN.”\*—This new book, so recently transferred from the publisher's desk to our own, we have examined with keen interest. We note that seven new chapters have been incorporated in the new, while two were dropped from the previous edition. Many of the old illustrations have been replaced by new and better ones, and the general air of neatness and thrift in the mechanical appearance of the book pleases at first sight. It is, however, more to the point to say that it is the subject matter that we are most taken with, and on this basis also we make the statement that this work adds a new and valuable contribution to homœopathic medical literature. The author knows whereof he writes, and he furnishes for willing readers a most sub-

\*“The Medical and Surgical Diseases of Women; a clinical and systematic treatise, by R. Ludlam, M. S., Professor, etc. Sixth edition. Revised, enlarged and illustrated, pp. 1,093. January, 1888. Halsey Bros., publishers, Chicago.”

stantial array of facts of scientific and practical import. It is also just to say that, as in the past, this book by this author has been the representative treatise, so far as the homœopathic practice in the treatment of the diseases of women is concerned, and so will it continue to stand by the advent of this new edition.

Practically, the last one-third of the book is new, and treats very largely of the surgical diseases of women, including diagnostic symptoms, methods of examination and exploration, pathological conditions, malignant diseases, and the surgical operations and their subsequent treatment. It is a mistake to suppose that the general practitioner has no lot or responsibility in the care of surgical cases. The demands are upon him to understand modern surgical methods, although he may not operate. The necessities of the after treatment of some of his own patients make it necessary for him to assume the care of the case. When therapeutic measures fail the practitioner should have the resource, or the realizing sense of what can be done in such cases by gynæcological surgery. It is a demand of the times, and the author has put special stress upon this part of his writings. No one can read these lectures without being impressed with the care and study bestowed upon each one, and the fact of how wide a circle of current medical literature has been laid under contribution in an exhaustive and painstaking manner. The author, with clearness and elegance of diction, has made a book to be read with interest and studied with profit. It would also be a mistake to think the book was designed for the specialist only. On the contrary, the chapters are written in the language of the lecture-room, where in fact the author has for so many years lectured on the diseases of women to hundreds of students. The text-book information is present in it from beginning to end. The clinical illustrations from hospital and private practice have made the work always of value, and, without doubt, this object-teaching, so long ago adopted by the author, and which is so popular now, has created the demand for this new edition.

Besides an introductory lecture, not to be found in former editions, there are two lectures on the pathology of ovarian tumors, one on explorative laparotomy and tapping, one on ovariectomy, one on the after treatment and results of ovariectomy, and one on the diseases of the uterine appendages, including the Battey-Tait operation. The surgical treatment of lacerations of the perineum and uterine cervix and also of uterine cancer have been reconsidered in the light of special experience.

Prof. Ludlam has seemingly read everything in this line, and remembered what he has read. The tabular statements of statistics, and the conciseness of his tables of differential diagnosis show an enormous amount of work in the arrangement of the acquired facts. There are many surprises by way of pointing out dangers, etc. We quote the following, under "tapping:" "Simple as it is, old as it is, and often as it is made by the general practitioner, the operation of tapping through the abdominal wall is not devoid of danger. In the old days when a dirty trocar and canula were often employed, and antiseptics was unknown, the mortality from tapping was greater than it now is from the capital operation of ovariectomy."

In the discussion which has so divided the gynecologists into opposing factions on the subject of antiseptics, the author presents the following views: "While the reaction against the early abuse of peritoneal asepsis, gynecologists are now divided into two camps—those who still resort to it in a more or less modified form, and those who, rejecting it altogether, prefer to depend upon absolute cleanliness as the safeguard against all septic and pyæmic mischief. Most operators of experience belong to the former class, and even when they do not use antiseptics during the operation, insist upon all sorts of pre-operative precautions and of post operative dressings.

My own idea is that the middle course is the safer one. Indeed my practice has been to combine the two methods, for I have failed to see how they could conflict. Surely there is nothing inconsistent between cleanliness and careful antiseptic, and under the varying conditions in which we are called upon to operate, it would not be best to depend upon either of them exclusively. There can be no valid argument against the middle course, and this view, while it expresses a deal of common sense, will readily commend itself to the thoughtful reader.

When we took up our pen, it was to note the long-looked-for arrival of a book familiar to us through frequent use, but there is so much of truth, and so fluent and clean is the style in writing the same, that we have been loth to lay down the weapon that is mightier than the sword, until we should have singled out almost at random, some of the bright nuggets of medical treasures and transform them to these pages. Our author still instructs us, as has been his wont, and as we sit and read, the earnestness of the teacher forces the belief that very many of his pupils and professional friends will unite to congratulate him upon the comely appearance and timely issue of this edition of this popular and useful book.

E. S. B.

## Hospital Notes.

### THE CLINIC OF PHYSICAL DIAGNOSIS.

SERVICE OF PROF. B. S. ARNULPHY.

**PHTHISIS AT THE SECOND STAGE.**—*Case 19296.*—August 30.—Miss K—, a girl fifteen years old. A year ago, when the menses first appeared, she flowed eight days. Since that time she has not had a return of the period, but every month she bleeds at the nose and spits some blood also, sometimes quite profusely. She had a cough for a year with muco-purulent expectoration in the morning, with occasionally a few streaks of blood. She presents a slight protrusion of spinal column at eighth dorsal vertebra, which is painful to pressure. The mother says the pain in the spine was the first thing the child complained of. She is herself affected with persistent cough and chronic bronchitis. The girl is somewhat emaciated, pale and languid, with a poor appetite. Pulse 90; no diarrhœa; little or no night sweats.

*Examination.*—Weak expansion of the lungs; depression of infra-clavicular regions more pronounced on the left side, which also exhibits a pretty high-pitched percussion sound, whereas the corresponding region on the right side has an almost clear resonance. On auscultation, vesicular murmur greatly exaggerated at the apex of right lung, with prolonged expiration.

Breath sound pretty nearly normal at left apex with the exception of a few sibilant râles, but more careful examination discovers a very limited patch of softening, first at the top of the left lung, almost beneath the external extremity of clavicle, where scanty, moist, crackling râles are perceived on inspiration. There is a pretty large area of sub-crepitant râles mingled with a few moist cracklings of larger size in upper and middle part of the right inter-scapular region, increased vocal resonance, and a muffled percussion sound, with signs of diffused but slight bronchial catarrh in the left corresponding region.

The case being seemingly one of phthisis of rather torpid character, with sluggish general reaction, and pronounced anæmia and mal-nutrition, as illustrated by the vicarious menstruation through epistaxis and hæmoptysis, as well as by the

obscure morbid process developing in the spine, the prescription was *Pulsatilla* and *Calcarea phosph.* 3, alternately.

August 27.—Feels a little better generally, but has more pain in the back. Slight fever last night, when the face flushed some and became spotted. The same remedies.

September 3.—The cough is worse, especially in the morning. Felt feverish at close of the day, and pain in the back is always present. Pulse 100. *Pulsatilla* continued in alternation with *Lycopodium* 30.

September 10.—Complains of sharp pain in the left side three or four times a day. Has also had headache this week, worse in the afternoon; but generally speaking feels stronger, eats more and digests better.

On examination, the softening process goes on unabated; however, expectoration is scanty, except in the morning. Moist crackling râles are now numerous at the left apex, and the area of infiltration in the right inter-scapular region has also enlarged. The same remedies.

September 17.—Feels stronger, but coughs more. Has had some pain in the region of the heart this week. *Arsenicum iod.* 6.

This interesting little patient did not return, and nothing has been heard of her since. Her case was a serious one, still one that could have been favorably modified had she persevered in her treatment, as there was some hope of restoring the menstrual flow, and of thereby effecting a decided change in the nutritive process conducive to better health.

REFLEX UTERINE DYSPNŒA.—MENOPAUSE.—EMPHYSEMA.—  
Case 19300.—Mrs. Z. O., æt forty-six, of full habit of body, complains of occasional attacks of pressure in the chest, during which she feels as if the air could not get out of the lungs. This condition has been growing upon her for three years back, together with a uterine trouble, the nature of which can not very well be defined. *She now notices the attacks mostly before the menses, which are becoming irregular.* Suffers acute pain in the abdomen when she catches cold and when coughing.

Physical examination reveals a pretty large lipomatous tumor occupying the root of the neck at the nucha and the upper part of left shoulder. Chest fully developed, clear pulmonary sound, with a light tympanitic shade to it, weak vesicular murmur, almost absent on expiration, diminished vocal resonance, normal heart-impulse.

These signs, though indicative of a certain degree of emphysema, fail to explain the recurring attacks of dyspnoea, inasmuch as the arterial system seems free of atheromatous condition, excluding thereby the possibility of chronic aortitis. We, therefore, feel justified in ascribing that peculiar symptom to a reflex uterine trouble (laceration of cervix?) probably exaggerated by the menopause. The patient was given *Lachesis 30*, and referred to Prof. Ludlam's clinic.

INCIPIENT PHTHISIS WITH INTERCURRENT RHEUMATISM. IMPROVED.—*Case 19298*.—August 27, William O., age sixteen, has been coughing for the past few months, mostly in the morning, with inability to raise anything, except, sometimes, in the early morning or evening; dull pain all through the chest when coughing; coughed more or less all the summer; feels feverish in the afternoon; catches cold very easily, and then it settles in his throat; has been feeling weak for about eighteen months, has frequent attacks of diarrhoea, especially in the winter; frontal headache, but no hæmoptysis.

The lad exhibits a weak frame of body. He is pretty tall for his years, and has grown up quite rapidly of late. The skin is flabby and colorless. The chest is long and narrow, poorly built, and shows a sluggish expansion of the lungs, of the right especially, at the apex of which we find a harsh inspiration, somewhat jerking in its rythm, and a few dry cracklings. The expiratory sound is rather prolonged, muffled percussion sound over the right infra-clavicular region, where vocal and cough-resonance are slightly increased. *Calcarea phos. 12* twice a day.

September 7.—No better; complains of stitches in the left side; had to go to bed yesterday, though neither chill nor fever were present. *Bryonia 3*, three times a day.

September 10.—The pain has not abated much, and shifts from one place to another. Besides the lad now shows decided signs of rheumatic swelling of the ankles, and suffers pain in the lower limbs. The cough, however, is not so troublesome.

We have, no doubt, to deal with a rheumatic complication, setting up intercostal neuralgia in the left side of the chest, where careful examination fails to detect any suspicious sign. Prescribe *Rhus tox 3*, three times a day.

September 17.—Is considerably better in every way. The rheumatic pains in the limbs have left, and the stitches in the side are neither so frequent nor so painful. The cough is

much less and easier. Examination confirms the above data; there is certainly a better type of respiration at the right apex, more expansion of the lung tissue, and a softer vesicular murmur. Curiously enough it seemed as if the rheumatic complication had carried before it the threatening lung symptoms. We generously dedicate the case to those who advocate the antagonism between the rheumatic and tuberculous diathesis, although we decline to take stock in the theory, for we have observed distinct proofs to the contrary.

In presence of this remarkable quiescence of the whole system, and feeling this was a most propitious time for furthering the improvement of the case, we prescribed *Sulphur 30*, once a day.

October 1. The lad feels brighter, he eats more and coughs less. *Sulphur* is substituted by *Jodium 6*, twice a day.

CHLOROSIS AND RHEUMATISM WITH MITRAL INSUFFICIENCY.—

*Case 19299.*—Ella O., aged twelve, is the younger sister of the last named patient. They used to come to the clinic together. This girl has palpitation upon exertion. She cannot lie on the left side, for she has a pain of a stinging nature as soon as she turns on that side. She sometimes feels very dizzy, especially when stooping. She has not yet menstruated, but in May, last, she had a nose-bleed which lasted with remission for three or four days. Has complained all summer of rheumatic pains, particularly in the ankles and the wrists. She offers a perfect picture of the chlorotic condition. The mother tells a history of a discharge from the ears the child has had for the past five years, with the remark that when it is free, the child seems better. This would interest the old humoralists.

Upon examination the heart-impulse is found to be exaggerated, the apex-beat being slightly displaced downward, and spread over a larger area than normal. A soft, blowing murmur is perceived during the systole, which is best heard at the apex, not covering the totality of the first heart-sound, and propagated to the carotids and sub-clavians.

Here is, seemingly, a nice case for discrimination between an anæmic and an organic murmur; still we are inclined to think there was at the time a mixture of both conditions. No doubt the heart already labored under the mischievous influence of the rheumatic poison; but no distinct lesion had yet been produced beyond a slight increase in the bulk of the organ, from the overwork caused by almost continuous palpitations. Now, were palpitations induced by the chlorotic

condition, or rheumatism, or both? It is hard to say, yet we incline to believe that the chlorosis preceded and prepared the way for the decided rheumatic invasion. *Ferrum phosph.* 6, three times a day.

September 3.—Feels better. Has had the rheumatic pains only once, last Saturday. The same remedy continued.

September 10.—Had a bad week. The child has caught cold; has had chills and fever almost every day with erratic pains, and feels a sense of pressure in the region of the heart; pulse 100, full and compressible; tongue slightly coated; the apex-beat is strong, and the chest-wall being thin and elastic, it creates quite a heaving motion in the fifth and sixth inter-spaces, where a systolic thrill is felt by palpitation. The blowing murmur is much louder, and has lost its soft character. It now covers almost entirely the first heart sound, and distinctly propagates to the left. It is also faintly heard in the left vertebral groove on a level with the angle of the scapula. We must admit that within the last six days endocarditis has been developed in the left ventricle, chiefly affecting the mitral valve. The child is advised to go to bed and take *Aconite* and *Rhus tox*, 3, alternately every two hours.

September 17.—The patient puts in an appearance, and reports a little better. No perceptible change in the murmur, but the heart seems less excited, and the pulse only beats ninety per minute. Same remedies.

October 1.—Better. No feeling of pressure, no palpitation. Dizziness occasionally. No rheumatic pains since her last call. The acute symptoms having abated, but no marked change being noticed in the murmur. *Naja trip.* 3 was given.

October 12.—Complains of palpitation again. Feels thirsty and drinks large quantities of water. The murmur has changed for the better; it certainly is softer and not so loud. The heart-impulse is moderate. Pulse 80; rather weak. *Arsenicum* 30.

Since then the child disappeared from the clinic with her brother. The prognosis is not quite unfavorable, as recovery could be expected under proper management. The probabilities, however, are that the endocardial lesion will assume a chronic form, and perhaps the insufficiency may turn into stenosis through the slow constriction of the fibrous ring of the valve. Indirect compensatory hypertrophy of the right ventricle is bound to set in, but how long it will do effective work is more than we know. Chlorosis, in such a case, is a serious hindrance. For an acute return of the trouble may always be feared, and make things worse.



PHthisis—THIRD STAGE.—*Case 19311*—was brought to the clinic by Dr. B. Snyder, of Bangor, Mich. Miss Etta P., age thirty-four, has had lung trouble for past four years, when she took cold from getting wet. It began as a sore throat with slight cough, which for six months seemed entirely confined to the throat. It did not extend to the lungs until eighteen months after the first attack. Expectoration was of mucus unless she was exposed to the wind, when it became tinged with blood. One year later hemorrhages came about once a month, and did not return since last winter. Menses have kept pretty regular. The cough now is worse, and comes in paroxysms caused by any exertion.\* Has lost flesh little by little. In February, 1884, she fell down stairs and injured her spine in the dorsal region, which has been very painful since, and has grown much weaker. Every exertion causes pain through the right side. It must be noticed that the first hemorrhage occurred in June following the accident. She had various scrofulous troubles during childhood.

This patient presents a marked emaciation; her complexion is sallow, with a yellowish tinge. Both infra-clavicular regions are sunken, and expand but very little, especially the right. There is a marked dullness at both apices; the right apex exhibiting a high-pitched tympanitic resonance, higher when the mouth is closed. By auscultation, amphoric breath and voice-sound, at the right apex, with large, gurgling rales when coughing, moist crackling rales diffused around. At the left apex bronchial respiration with cavernous rales. Large zone of subcrepitant rales in the right and inter-scapular region. A sharp pain is elicited by pressure at the sixth spinous process, extending along the seventh rib to the sternum. The integument covering the said rib and spinous process seems to be slightly swollen.

We, therefore, diagnose a case of phthisis at the third stage, since a large cavity is present at the right apex, whereas at the opposite side a smaller and more recent cavity can be detected, surrounded by a zone of infiltrated lung tissue, which is undergoing the softening process. A similar condition is also brewing in the back part of the right middle lobe. Pulse 110, weak; skin dry and hot. In spite of the absence of colliquative symptoms, and of the fact that the menses are not suppressed, such a case is not promising. When coupled with cough and fever, they point to anto-infection, and such a condition, when prolonged, is inimical to life. We advised to rely mostly upon *Silicea 200*,

\*Muco-purulent expectoration.

which the scrofulous constitution of the patient and the actual suppurative process seemed to indicate, and whose action might occasionally be sustained by *Calc. Arsen.*, *Calc. iod.*, *Arsen. iod.*, *Hyosciamine*, in third trituration, might be given for the paroxysms of cough at night. Besides, it would be a good thing to put the patient upon a vegetable diet, according to Jousset's practice in similar cases.

BRONCHITIS—DRY PLEURISY. — *Case 19302.* — September 10. — Robert W., age forty-five, has been coughing for some weeks past. There is not much expectoration now, but there was formerly. He had a severe pneumonia twenty-two years ago, from getting wet. He coughs mostly at night, beginning as soon as he goes to bed. Feels heat and soreness behind the sternum. There is some pain in the stomach after taking food. But what now brings him to the clinic is an annoying pain which he has had for a week or so in the sides of the chest. The pain seems to shift about, being worse on the right side to-day, while yesterday it was worse on the left. Broncho-vesicular breathing in both upper lobes, with some sibilant and wheezing râles heard here and there in both inter-scapular regions. The ear defines pleural dry friction sounds, of a rasping character, over the right infra-axillary and infra-scapular regions, where the percussion sound is slightly raised, and vocal fremitus somewhat muffled. No œgophony. There is no fever, no waste of the system—the case being simply one of sub-acute bronchial catarrh, complicated by a moderate inflammation of the pleura, thus far without effusion. The absence of fever and the shifting character of the pain we took for favorable signs, which made us hope that effusion could be avoided. *Bryonia* and *Capsicum* third were prescribed.

October 14. — The man did not return, but his wife, more than a month afterward, triumphantly stepped into the clinic room, with a flood of fine words, which, in short, meant that her husband had been steadily improving from the day he began to take his medicines; that both pain and cough had left him, that he was hard at work, had no time to come, and only begged for a little more of the same medicine to do away with a little tickling he at times felt in the throat. This garrulous lady was given *Hepar sulph.* 12, and dismissed.

It is not the first time that I have tested the virtues of *Capsicum* in preventing pleuritic effusion when given early. An old French practitioner pointed out the fact to me, and I never saw it fail since. Let it be recorded once more.

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*ALUMNI ANNOUNCEMENTS.*

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The fifth annual meeting of the Alumni Association of Hahnemann Medical College and Hospital, will be held in Chicago at the Hotel Richelieu, Wednesday evening, February 15, 1888, at 8 o'clock.

The exercises will consist of the regular business of the association, an address by the President, Dr. C. M. Dinsmore, of Omaha, Neb.; reports by the secretary, treasurer, necrologist and other officers. Another pleasant feature will be the call for five minute speeches from all members present.

At the last meeting a large number of alumni came together and had an enjoyable time relating experiences and recalling "old times." It is hoped that this meeting will surpass all others. Every alumnus should make an earnest effort to be present.

The Twenty-ninth Commencement exercises of the Hahnemann Medical College and Hospital will take place Thursday afternoon, February 16, 1888, at the Grand Opera House.

Thursday evening, February 16, 1888, at 6:30 P. M., the annual banquet of the alumni, faculty and the graduating class will be held at the Hotel Richelieu.

In order that definite arrangements may be made it is requested that those who intend to be present communicate with the secretary as early as possible. Seats for the banquet will be reserved until February 16. Tickets per plate \$3.

H. V. HALBERT, *Secretary.*

2400 Prairie Avenue, Chicago, Ill.

**SPECIAL NOTICE.**—Physicians and Alumni who are in town for the Commencement Season, February 15 and 16, will obtain special rates at the Hotel Richelieu.

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# THE CLINIQUE.

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## Original Lectures.

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### *LITHÆMIA—CALCAREA CARBONICA.*

BY C. E. LANING, M. D., ASSOCIATE PROFESSOR OF THEORY AND PRACTICE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

#### LECTURE II.

In studying this remedy in connection with lithæmia, unless you have already given some thought to the subject, I am sure you will be surprised at the many symptoms which show the profound action of this substance upon the liver. While by some physicians it is recognized as a great hepatic remedy, by the majority its efficacy in this line is either underrated or entirely overlooked. You remember that lithæmic patients, as a rule, are disinclined to mental effort, and not only so, but they are troubled more or less with confusion of the intellect; are unable, even if desirous, of holding the mind upon any subject, and frequently have all sorts of forebodings with great depression of spirits. Under this remedy we certainly find symptoms strongly indicating this condition. The following is a well marked symptom both of calcarea and of lithæmia: "Thinking is difficult; disinclination for every kind of work; depression and melancholy; tearfulness." This symptom is not infrequently found in cases of uterine derangement, but the fact that the affection of the uterus is secondary to hepatic irregularities is often overlooked. Other symptoms of this remedy corresponding to the mental or cerebral symptoms of lithæmia are: "Apprehensive mood, as if some misfortune were about to

happen; fears that she will lose her reason, or that people will observe her confusion of mind; irritable without cause." This irritability is not really without cause, only so far as external or objective causes are concerned, it being what might be termed a "subjective" irritability, due to the disturbances of the circulation within the brain, as well as to the abnormal composition of the blood.

You remember the tendency to attacks of vertigo in lithæmic patients; under calcarea we find the following symptom: "Vertigo, when walking in the open air, as if he would reel, especially when turning the head quickly, or going upstairs; worse in the morning, with nausea and vomiting." The last part of the symptom furnishes the key to the cause of the vertigo, pointing clearly to gastro-hepatic derangement. The tendency to localized congestions in this disease is decided, and the symptom which I shall next give you serves to continue the parallel between the remedy and disease under discussion. "Rush of blood to the head, with heat, redness and puffness of the face, worse from alcoholic drinks; worse in the morning on waking." This symptom serves still further to call our attention to the injurious effects of alcohol upon the liver, showing its tendency to produce such functional derangement as gives rise to that group of symptoms which are termed lithæmia. Not only so, but it also suggests the use of calcarea in the earlier or incipient stages of cirrhosis of the liver, the most prominent etiological factor in this disease being, as is well known, the undue use of alcohol.

The aversion, and indeed oftentimes inability, of the lithæmic patient to any mental effort corresponds closely to the following calcarea symptom: "Continued dullness of the head as if too full, with feeling of stupidity; worse from reading, writing, or any mental exertion." In such cases there is undoubtedly present a more or less defined congestive or hyperæmic state of the cerebral capillaries, which, if any mental effort is attempted, naturally become more highly dilated, since it is a fundamental physiological fact that all tissues, when thrown into a state of functional activity, have their blood supply increased. Not only is this true in the normal state, but also when it is highly congested as a result of disease. Hence a hyperæmic brain, stomach, liver or kidney will show symptoms of aggravation whenever its functional activity is overstimulated.

Headache is a frequent symptom of the malady under consideration; therefore, when we find under calcarea "frequent one-sided headache, always with much empty eructation," we can not fail to perceive its significance, when occurring in this class of patients. You should learn, not merely to interpret the significance of a group of symptoms, but of single symptoms as often as possible. This will not only aid you in the selection of a remedy, but it will indicate the nature and location of the lesion, and thus afford an intelligent idea as to *where* to look for other symptoms. It will explain their nature, and thus keep you from blindly inquiring for some landmark, some "characteristic" which, when found, has no meaning, no real clinical significance. It is true that a remedy may act just as well without our knowing *how* or *where* it acts, and it is equally true that the *right* remedy, prescribed by the veriest blockhead, will produce a favorable change in the patient as promptly and as permanently as though it had been given by the most scientific physician in the world; but *which physician will prescribe the correct remedy the greater number of times for a given number of patients?*

The tendency to throbbing of vessels within circumscribed limits, which occurs in lithæmia, is observed in the following symptom: "Throbbing headache in the middle of the brain every morning; lasts all day." You will recall a symptom quite similar under *Bryonia*: "Throbbing ache on top of the head, morning when walking." "Headache worse when going upstairs, walking in the hot sun, from taking cold, better from tight bandaging, closing the eyes; vomiting mucus and bile." The last part of the symptom gives us the key to the cause of the headache, while the causes of aggravation and amelioration show it to be proximately due to congestion.

Let me now call your attention to a group of eye and ear symptoms, which you will at once recognize as the counterpart of those given under lithæmia: "Swelling and redness of the eyes, with nightly agglutination; during the day full of gum, with heat, smarting pain and lachrymation." This is a symptom met with under different remedies, and which is not often recognized as due to hepatic disturbance; occasionally it arises from simple gastric catarrh, and is almost purely a catarrhal symptom, resulting from an affection of the lining membrane of the

meibomian glands. "Singing or roaring, or crackling in the ears, strange and peculiar noise in the ear when swallowing;" "pulsating in the ears;" "purulent, offensive discharge from the ears." Remember what was said about the tendency to inflammation and formation of pus in lithæmia. Symptoms like the last one mentioned, in connection with the ear and the one relating to the meibomian glands, are too often looked upon as purely local troubles, and remedies are prescribed because they are supposed to act locally and directly upon these regions or structures. It should not be forgotten that individuals have certain weak or susceptible points, *i. e.*, certain nerve centres or tissues are more liable to be affected by a given cause than are others. The sensitive centres vary in different individuals, and, indeed, at different times in the same individual. Thus, a person might to-day be exposed to the influence of the weather, and as a result have an attack of pneumonia; while at another time the same degree and kind of exposure might give rise to an attack of pleurisy or bronchitis, or, perhaps, only a simple coryza, or, indeed, cause no visible effects. Sometimes, therefore, a patient with a given hepatic derangement may have as an outgrowth of it some affection of the eyes or ears or throat, as the case may be. It will be found that the remedy which corresponds to the hepatic difficulty also covers the eye, or ear, or throat symptoms, or will cure three different patients, each having the same functional derangement of the liver, but each having a different set of reflexes, for the reason already given. It is a fact not to be lost sight of, however, that unless these reflexes are, so to speak, within a certain limit, or of a certain kind, even though we still speak of the hepatic affection by the same name, it is not to be relieved by the remedy used in the first case. Diseases resemble each other as do individuals—that is, all men are near enough alike to come under the general classification of men, but we must not treat every man alike—for this reason: Certain of them are so nearly alike that fear, persuasion, etc., will have almost an identical effect upon them all. So, certain diseases will be so similar in different individuals that the same remedy will remove it in each instance.

A word in regard to these reflexes: They are, as has already been stated, of the utmost importance if rightly interpreted. A

disease (looking upon it for the sake of illustration as an entity, a something) goes through certain steps or stages of development, and the ability to recognize it in all its stages or phases is what we should cultivate. We all know that, unless some powerful modifying influence is brought to bear, the infant will become the child, the youth, the adult. Unfortunately, we can not always tell, when a disease is in its infancy, to what proportions it may grow, or what shape it may assume. But the more skillful we are, the sooner can we do so. Thus, the scientific botanist can tell almost as soon as he sees the shoot of a plant above the ground into what it will develop; from the blossom he knows what kind of fruit will come. One great difficulty with which the physician has to contend is the fact that diseases resemble each other in certain stages. This—by way of illustration—in the development of blood corpuscles, those of the lower animals, when fully developed, are identical with those of a higher order when partially differentiated. Hence, if a corpuscle was given us for analysis, or for the purpose of our naming the animal from which it was taken, *if* we knew that the corpuscle was fully developed, we would have little trouble in assigning it to the right animal. But, if we did not know this, it would be a difficult task; for, while fully developed, it would *certainly* belong to a given species, but, if only half developed, and yet having the same characteristics, it would as certainly belong to another species, higher in the scale. Thus, when disease begins to make itself manifest through symptoms, we must know whether a given symptom is fully developed, so to speak—whether it represent the bud, the half-open, or the matured flower. If, speaking figuratively, it has the appearance of a bud, yet is nevertheless fully grown, it represents a symptom calling for a certain remedy, or indicative of a particular disease. I am satisfied that we are constantly liable to mistakes on account of ignorance. Thus, to-day we give one remedy, and on the morrow another, because, as we fancy, the disease has developed beyond the point where the first remedy can be of benefit; whereas it was all the time a rose which was growing, and should have been treated as such from its first appearance. If we had knowledge sufficient to recognize this, then we might literally be able to “nip disease in the bud.”



As an illustration from life, as it were, in the case of a patient suffering from neuralgia, we should note or be told that the pain gradually increased up to a point which seemed unbearable, and having elicited this much, should prescribe without waiting to learn that the pain disappeared as gradually as it came—a crescendo followed by a diminuendo—we would have prescribed for the bud instead of the flower. Of course, in such a case the development would be such that we would not be liable to make the mistake spoken of. But in diseases of slower growth, how shall we recognize whether the symptoms are partially or fully developed? How shall we know whether the corpuscle is fully developed, and hence must have come from the blood of a rat, or only partly formed, and, therefore, is from the blood of some animal higher in the scale? Only by taking into consideration all facts having a bearing upon the case; the habits, if necessary, of the person bringing the corpuscle; whether he would be more apt to have dealings with rats or human beings; any hairs of the rat or other parts of his body to be detected about the individual; any odor savoring of rats, etc. This may seem far-fetched, but I assure it is not. It is only by *careful, persistent, intelligent* observation of all phenomena connected with disease, that we can ever hope to make medicine a science.

“Very offensive smell in the nose, as from manure or rotten eggs; dryness of the nose, or stopped by fetid yellow pus; sore, ulcerated nostrils.”

While these are merely local symptoms in a certain sense, they nevertheless are indicative of more or less general or constitutional disturbance. You will find through close observation that nine-tenths of the cases of catarrh you may be called upon to treat will be due to hepatic derangement, most commonly the form studied under the name of abnormal disintegration. In making a study, then, of so-called catarrhal remedies make yourselves thoroughly familiar with the hepatic symptoms of said remedies, for often you will find cases of nasal, laryngeal, bronchial or gastric catarrh, in which, if only the symptoms directly connected with the catarrhal condition, *i. e.*, the character of the discharge, the quantity, the time of aggravation, etc., if, I say, only these things be studied, you will fail to select the proper or curative remedy. This is the reason for much of

the misunderstanding which exists between the so-called symptomatologists and pathologists of our school. Thus, the symptomatologist, having cured a case of nasal catarrh by the use of some remedy, the selection of which was determined by some symptom or symptoms apparently entirely foreign to the nasal difficulty, he at once assumes that a knowledge of pathology is useless, as in such a case there was no connection between the pathological condition and the remedy prescribed. But, where he and many others make a mistake is in considering the pathological changes which have occurred in the Schneiderian membrane as representing the true or entire pathology of the case, whereas it is only a portion of the pathological changes which represent the case in its entirety. He constantly says, "Take the totality of the symptoms," but assumes that the pathologist does as he does, *i. e.*, recognizes only a portion of the tissue changes which have occurred in the case.

The thorough pathologist is more likely to note all the symptoms in the case than is the mere symptom matcher. Why? Because he, the pathologist, knows the significance of symptoms; he knows that a nasal catarrh may be due to certain hepatic derangements; therefore he will look to that organ, and elicit any symptoms which may be connected with it. Further, he knows that the hepatic lesion itself may be secondary to a cardiac lesion, and, if it is, he knows that the heart affection must be removed before the hepatic trouble can be, or the nasal catarrh. He will of necessity know whether to select his remedy in accordance with the character of the nasal symptoms or of the hepatic symptoms; or, if the whole difficulty comes from a developing valvular lesion, or from a weakly-acting heart (which he knows in turn may be due to an affection of the par vagum), or of the cervical sympathetic, he will be governed accordingly, and know to which group of symptoms to give the preference. He, the pathologist, must of course not only know the significance of symptoms as regards the nature and the location of the difficulty which they indicate, but he must also know what remedy or remedies will act upon the structures involved, in such a manner as to produce a very similar, not to say an identical, condition. If he knows these things, he is prepared to make a scientific prescription, and not before.

Pardon the digression, but I feel that we must know what we *need to know*, before we can properly learn it.

You remember that in lithæmia there is a tendency to different affections of the skin and to the cropping out of various eruptions. Under calcaria we find that the skin gives evidence of hepatic derangement. Thus there are present "itching and eruption in the face and among the whiskers, moist, scurfy eruption on the cheeks and forehead, with burning pain; swelling of the upper lip in the morning; cracked lips; the corners of the mouth are ulcerated; painful swelling of the submaxillary gland; unhealthy, ulcerative skin, even small wounds suppurate; ringworms; itching over various parts of the body."

Here we have the lithæmic group of skin symptoms as found under calcaria. You will not forget that the origin of a large proportion of skin affections can be traced to the liver. In regard to this matter, one of the best authorities upon this subject, Dr. Tilbury Fox, says as follows:

"All disorders which are connected with excreta in the system, and their circulation throughout the blood-current, may furnish the exciting cause of eczema. This is a clinical fact of great importance. Given the tendency to eczema, then the transmission of uric acid through the capillaries of the skin will so far derange as to aggravate certainly, and now and again excite, an eczematous eruption. This is what is meant by gouty eczema, and, by securing the absence of uric acid from the circulation, the eczema will often disappear and always be more amenable to treatment. Such cases as I now refer to sometimes exist off and on for years, and are saturated with arsenic and mercurials, but are only relieved by recognizing the complicating item of the free production and circulation of uric acid, and by instituting a *regime* calculated to arrest the continuance of these conditions." Dr. Fox also calls attention to the fact that children with eczema often have white stools. This last condition is, as we know, quite a characteristic indication for calcaria.

"Anatomically there is nothing to distinguish these cutaneous eruptions from those due to other constitutional states, but it will often be observed that their invasion is sudden, and is attended with or preceded by dyspeptic symptoms, and that they follow the ingestion of food which has been known to disagree."

Ringworm, or herpes circinatus, which is mentioned as a symptom of calcarea, is also a prominent symptom of sepia, or at least this remedy is very often curative when this condition is present, so frequently, in fact, that it is referred to in some works as a "specific for herpes circinatus." It is well known that *Sepia* is a powerful hepatic remedy, and, indeed, I think as a rule you will find that all the remedies which have been found to be curative in this peculiar affection have a recognized and decided action upon the liver. Let me remind you, then, in the case of skin affections, to be always on the alert for hepatic symptoms while searching for the *simillimum*.

We note as lithæmic symptoms the following: "Taste sour, bitter, offensive; tongue coated white; burning pain at the tip of the tongue as from soreness; worse from warm food; soreness of the tongue either on the tip, sides or dorsum; can scarcely talk or eat; mouth slimy; blisters on inner surface of the cheek and tongue; canker sores, especially during teething; ravenous hunger in the morning; loss of appetite, but, when he began to eat, he relished it; will not eat meat; great thirst after milk; sour eructations and water brash; after meals heat or flatulency, with nausea and pain in the stomach and abdomen; eructations tasting of the food eaten—bitter, sour, or tasteless fluid; burning extending to throat; heartburn; pressing pain in the stomach as if a load or stone were in it, after a moderate supper, worse from motion, better from lying quietly on the back. This is a symptom, as you will remember, which has been mentioned as characteristic of lithæmia, *i. e.*, a feeling of weight or oppression in the region of the stomach. If you further remember what I told you in one of my anatomical lectures in regard to the condition of the bladder which gave rise to a sensation as if it were constantly full, you will have the key to the symptom of the stomach just mentioned. In lithæmia, there is almost always more or less engorgement of the portal vein, hence of necessity of the gastric also. The pressure exerted by the distended radicles of the gastric vein upon the nerves distributed to the stomach, gives rise to a sensation as if a foreign body, a stone or a lump, were in that viscus. The fact must not be lost sight of, however, that there is, accompanying the venous stasis, a modified or changed condition of the *nervus vagus* whereby the irritation resulting

from this blood pressure is translated, so to speak, into the abnormal sensation already described. Thus, *all* remedies or diseases which cause increased venous pressure in the mucous membrane of the stomach do not give rise to the symptom under discussion. Observe, therefore, that it is not the gastric venous stasis which serves us in discriminating between the different remedies that may be needed for its removal, but rather, the evidence of deranged or modified nerve action as shown by the feelings or sensations transmitted from the stomach by the nerves of that organ. Thus, if the case be one in which either *Calcarea*, *Bryonia*, *Pulsatilla* or *Nux vomica* will be curative, we will find that the nerves of the stomach will be deranged to such an extent, or rather in such a manner, as to give rise to a sensation of a lump or stone in the stomach, the said sensation being proximately due to the venous stasis which we have found to exist under all of these remedies, or in the various diseases in which they are curative. The same condition, *id est*, venous stasis of the lining membrane of the stomach, will, as we shall see later, give rise to different symptoms under other remedies. This should lead us to be very guarded in giving too much weight to the *gross* pathological changes or conditions which may be found in a given disease. From the fact that we make mistakes, and do not succeed in producing cures, if we base our prescriptions upon said conditions, from this fact I say, we should be led to see that the disease *itself*, so to speak, is in the nerve centres, and is not represented by the pathological changes that we see in the organ which is said to be diseased, or to be the seat of the disease.

In short, *all* disease results from modified action of some nerve centre or centres. Now, different centres may be so affected as to give rise to groups of symptoms, which, in a general way, so closely resemble each other as to be classed under one heading, or, in other words, they receive the name of a certain disease. Do not lose sight of the fact, however, that, while the group of symptoms in one case may resemble those in another, to such a degree that they both come under the head of lithæmia, nevertheless the nerve centres which have given rise to the first group may not be—need not be—the same as those which have given rise to the second group of symptoms.

Or, if the *same* centres are involved in each case, they are so dissimilarly affected as to require different remedies to remove the morbid impressions under which they are laboring, and as a result of which there has arisen a group of symptoms which we term disease.

*Nothing can be more fatal to scientific medicine than the attempt to prescribe for a disease by its name.*

But to proceed with the symptomatology of the drug under consideration: We find a peculiar symptom in connection with the stomach, viz., "Pit of the stomach swollen like a saucer turned bottom-side up." Now, what does this mean—what does it signify? It is not merely due to a collection of gas in the stomach, else *Lycopodium, carbo veg.*, and other remedies which produce large quantities of gas would have the same symptom. Without going into detail as regards the location of the centre at present, suffice it to say, that there is a cerebral centre which presides over the action of the muscles of the stomach and the intestines. You will remember I told you, during a lecture the other day, that cerebral centres might be so affected as to produce contraction, spasmodic action, or paralysis of single muscles or groups of muscles. In this case, then, certain of the muscular fibres of the stomach are so contracted as to give rise to the peculiar shape of the organ spoken of in the symptom quoted. As an illustration of this kind of nervous action, I may refer to a symptom under *Belladonna*, which is produced in an analogous way. Acting upon a portion of the cerebral centre which causes contraction of the circular fibres of the colon, this drug, by producing tonic spasm of the circular fibres located at (generally) the hepatic and splenic flexures, and thus holding imprisoned the gas between these points, gives rise to the symptom described as a "protrusion of the transverse colon like a pad."

Next comes a group of symptoms, which indicate a hyperæsthetic condition of the spinal nerves distributed to the hypochondria. They are: "Tight clothes about the hypochondria are unbearable (*vide Lachesis*); feeling as if laced below the hypochondria, with trembling and a throbbing in the epigastrium; feeling of tightness in both hypochondria.

Other symptoms will now follow, which you will all recog-

nize as belonging to lithæmia. I should like to give you some idea as to their significance, but can not possibly do so, as this remedy has already extended far beyond the limit intended.

“Abdomen much distended, hard; frequent severe cramps in the intestinal canal, especially in the evening and at night, *with coldness of the thighs*, feeling of coldness of the abdomen; obstructed flatulence; flatulency and gurgling in the right side of the abdomen.

“Stools, yellowish, gray, clay-like, fecal; constipation, stools large and hard, containing undigested food, and often accompanied with slime; discharge of blood from the rectum—oozing of a fluid from the rectum smelling like herring brine; feeling of heaviness in lower part of rectum; urine very dark colored, *offensive*, dark brown, with white sediment (*urate of soda*).

So far as the respiratory apparatus is concerned, there is evidence of imperfect disintegration taking place in the liver; thus, there is much mucus in the bronchi, often yellowish and putrid, also a tendency to formation of abscesses in the lung.

I need make no comments on the following symptoms: Palpitation of the heart, with anxiety, at night or *after meals*; tremulous pulsation of the heart, *worse after eating*; pulse full and accelerated, often tremulous; *much beating in the blood vessels*; pain between or in the region of the scapulæ; cramp in the whole of one or the other arm; pain as if from a sprain in right wrist, or as if something had been wrenched or dislocated; finger joints much swollen; felons, hangnails (*gout and rheumatism*); weakness and weariness of all the limbs; cramp in the calves at night, about 3 A. M., also in the hollow of leg, when stretching out the leg, *in the sole or toes*; burning in the soles (*vaso motor. Sul. Lach., etc.*); *feet feel cold and damp*.

The sleep is poor, as shown by the following symptoms: Late falling asleep—not until 2 or 3 A. M.; wakes too early, can not sleep after 3 A. M. (*Nux., Kali carb.; Ign.*); sleepiness and weariness by day; very great sensitiveness to cold air, takes cold easily.

This last symptom is not necessarily one of lithæmia, but often may be looked upon as an etiological factor. The patients in whom the calcarea train of symptoms are the most liable to occur are those in whom this condition of the skin is most frequently found. When the skin is so sensitive to the cold, it of necessity has its function more or less deranged. Lowered functional activity of the skin increases the work of the mucous membranes, the kidneys, or the liver, or all, and in this way acts as at least an exciting cause in the case of patients predisposed to the functional derangement of the liver, which in turn gives rise to the group of symptoms which we name lithæmia.

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## Clinical Society Transactions.

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JOSEPH P. COBB, M. D., SECRETARY.

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The regular monthly meeting of the Clinical Society was held in the club-room of the Grand Pacific hotel, on Saturday evening, February 4, Dr. G. F. Shears, president, in the chair. In the absence of Dr. Cobb, Dr. W. S. Gee was chosen secretary *pro tempore*. Dr. M. C. Sturtevant was elected to membership. The session was occupied with hearing the

### REPORT OF THE BUREAU OF THE DISEASES OF WOMEN.

DR. R. LUDLAM, CHAIRMAN.

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This report included several brief papers by the Chairman, and two volunteer papers by others, all of which were upon gynecological subjects. These were presented in the following order, the first only was read in full, and the others were presented in abstract:

I. SOME AVOIDABLE SOURCES OF MISCHIEF IN PERI-UTERINE CELLULITIS.—From an abundant experience in the management of pelvic cellulitis among women, I am persuaded that there are certain avoidable causes of mischief upon which the proper emphasis has not been placed by the majority of practitioners and teachers; and it has occurred to me that some of them might be considered with profit by the members of this society.

1.—*Of the ill effects of travel in cases of this kind.*—Not the least remarkable and grateful of all the good results that have accrued to the public through the invention and perfection of the sleeping-car system by our friend and neighbor, Mr. George M. Pullman, is the possibility of conveying our invalid women from one end of the country to the other, in



the recumbent posture, for a change of climate and for a change of treatment also, whenever such expedients become necessary.

Concurrently with the expansion of the country and the development of its resources, both of soil and of climate, and with the improvement in a branch of medicine and surgery that is devoted especially to the relief and cure of this class of patients, comes the possibility of transporting them with little comparative risk and the greatest comfort wherever and whenever we please. The benefits to be derived from a change of air and of scene, of diet and of diversion, as well as from the skill and experience of the distant specialist, are thus made available through the safe and speedy transfer of all those American women who are compelled to leave home in order to regain their health.

The man who first devised this species of ambulance is a public benefactor. If the comfort and the luxury of the sleeping-car service were limited to those, who, being ill, must not only go away from home, but must be carried in as careful and as kindly a manner as possible, the public welfare would still demand that it should not be discontinued. But these travelers are not caged like so many criminals to worry and to infect each other with their bad feelings and sorrowful experiences. They mingle with the multitude of well-to-do and busy people who are on the wing, and thereby get the benefit of contact with the great breezy world that lies outside of the sick chamber.

No one is better fitted to appreciate this modern method of transportation than the gynecologist. He knows how important it often is for his patients to travel, and how impossible it would be for many of them to make a journey without harmful consequences if they could not lie down on the way. To him and to those who must depend upon his advice and his help the railway has more than one road-bed, and the sleeping-car is a double blessing.

But, while most women who have pelvic and menstrual disorders are thus enabled to travel with comparative impunity, there is one condition in which I am satisfied that the risks

of removal are still very great, and that condition is one of peri-uterine cellulitis with recurrent abscess.

Not to speak of the arrangement and the clinical history of the other tracts of areolar tissue within the pelvis, so much of it as lies between the layers of the broad ligaments and directly about the womb is possessed of a peculiar interest. Its elastic threads are intimately concerned in the mobility of the uterus, and in its being restored to and retained in its proper position. And as an intervening texture, through which its blood supply is regulated, this tissue is quite as important as any other in the neighborhood. Its proneness to congestion and to inflammation, to induration from the effusion of serum into its meshes, and to suppuration, especially in scrofulous and cachectic subjects is well known. Its susceptibility to traumatic influences, particularly to those which determine the blood within the pelvis, and which cause it to remain there, or to circulate in a very sluggish manner, is acknowledged by our teachers and writers with more or less practical emphasis.

But the importance of absolute rest as a means of cure for these cases, and of keeping the patient from being injured by sitting up or moving around, or going off on a journey, no matter if it is in a sleeping-coach, is not fully appreciated. The consequence is that there is no discrimination in favor of this class of sufferers, and a woman, who, if she were kept at rest in her bed might recover from an attack of cellulitis without any troublesome sequelæ, is made to become a chronic invalid with relapsing abscesses and anchorage of the uterus from which she may never again be wholly free.

There are cases of pelvic cellulitis in which the inflamed tissue is bruised and injured by straining at stool, or in urination, and others in which the concussion of a cough will perpetuate the mischief. Dr. Thomas says very impressively: "Absolute rest should be enjoined, the patient not being allowed to sit up in bed for a moment, upon any pretext whatever. Were I limited to one remedial resource in this affection, I would choose rest in preference to all others, but to accomplish anything it must be absolutely enforced."

If this treatment is so very important, and if the slightest

exercise may do so much harm in these cases, it is our manifest duty to keep them off the cars until all evidence of pelvic mischief, and all the tokens of areolar inflammation, with or without abscess, have disappeared. Other cases coming within the scope of gynecology may travel, especially in the sleeping-car, or by steamer, without risk, and often with much profit; but these are more likely to be injured than benefited by the inevitable jar and traumatism of a journey.

2.—*The physical examination of the patient under anaesthesia.*—There are conditions under which we can not make a full and satisfactory examination of our lady patients without the employment of chloroform or ether by inhalation. Such cases will readily suggest themselves to the minds of the members of this society.

The converse of this proposition is equally true. And not only are there instances in which we may obtain more information without anaesthesia than with it, but there are diseases and circumstances in which the insensibility of the patient is not to be desired, and may indeed be very mischievous. For pain has its uses, and nowhere is its language more significant than in differentiating between certain pelvic disorders. To suppress it, and to place the patient where she can not tell us how she feels is to rob us of half that we might otherwise learn from the examination, and possibly to destroy her only safeguard against injury at our hands.

Whoever places a woman with peri-uterine cellulitis under ether or chloroform and then passes the uterine sound will hardly fail of doing her some harm before it is removed. If to this is added a rough bi-manual examination, the chances are that he will do more mischief in a few minutes than he could repair in as many months, or perhaps in a lifetime. And yet this thing is practised without hesitation, and without a thought of the possible consequences by some of those who pretend to be gynecologists.

“The sound is one of the most valuable instruments for diagnosis that we possess, and it is no less valuable in treatment when properly employed. It is as the compass to the mariner, as the steam-gauge to the engineer. But I insist that it should be used with care, with gentleness, with intel-

ligence. The gynecologist must remember that he is dealing with a delicate organism which requires no rough handling; that it is not to be whipped into obedience as though it were a responsible being, but that gentleness and firmness intelligently exercised will exact a ready compliance with what it is fair to demand." \*

3.—*The abuse of the pessary in cases of this kind.*—Manifestly no one is fitted to discuss the value of the pessary unless he is experienced in its employment. Nor can he fairly consider the merits or the demerits of this instrument until he is able to distinguish between those displacements of the womb that are simple, and such as are complicated with peri-uterine inflammation. Any dislocation of the uterus that is of more than temporary duration is certain to be mischievous, and will need to be remedied. But the conditions that accompany or follow such deviations are neither common to all cases nor constant in any one of them. Hence their clinical importance, and hence the necessity of a careful discrimination in the choice of mechanical means for their relief.

The simple truth is that there are comparatively few cases of uterine displacement, which have become chronic that are not complicated with some form of peri-metritis. It is the textures *around the womb*, and not those which enter into its formation that are most seriously involved; and the nature and drift of these lesions is such that they must not be forgotten when we come to consider the propriety of fitting a pessary for the relief of the version, or the flexion, or the prolapsus.

Now the form of pelvic cellulitis under consideration is the lesion that is most likely to complicate a serious malposition of the uterus. The suffering that is involved, as well as the resulting suppuration, shows how the mechanical pressure of the womb itself increases the difficulty. It also shows how intolerant the inflamed areolar tissue is of pressure, and why, in such a case, a pessary would not only hurt the patient severely, but would do her more harm than good. I have certainly met with cases in which the traumatism of the inflamed

\* Bantock "On the Use and Abuse of Pessaries." London, 1884, pages 73, 74.

cellular tissue by a misused pessary had resulted in the formation of relapsing abscesses; and I am persuaded that whenever we forcibly reposit the womb, and apply an instrument to retain it *in situ* regardless of the condition of the web in which it is swung, we shall only make matters worse instead of better.

3. *Constipation*.—Such is the forced inactivity of these patients, and such their usual diet, that constipation is an inevitable and an almost unavoidable condition with them. The mischievous effects of torpidity of the rectum, and of fecal accumulation therein, ought to be evident. But there is such a disposition with many if not with most of the practitioners of our school to disregard this symptom, and to question its clinical import, that I must mention it as an avoidable source of suffering in pelvic, and especially in peri-uterine cellulitis. The toxic effects of direct fecal absorption, included under the term copræmia, and the peculiar anæmic condition growing out of it, which has been shown to have a causal relation to chlorosis, especially in young women, can only be remedied by keeping the bowels open. Indeed, in many cases the constipated habit perpetuates the difficulty, and prevents our remedies from acting as they would certainly do if this complication did not exist.

But it is important to remember that the form of constipation which is an obstacle to the cure of pelvic cellulitis involves the collection and the retention of fecal matter in the rectum. In order that the bowels may be kept clear, it is not necessary to resort to the habitual use of cathartics, which would soon increase the difficulty. The simple and direct indication is to unload the most accessible portion of the intestine, and to keep it so free from obstruction, as that the neighboring parts shall not suffer either from mechanical pressure or poisonous absorption. This can best be done by enemata of warm water, containing two tablespoonfuls of olive oil to the pint of water. As a rule two of these injections should be taken within an hour; the first, which empties the bowel, is to be passed very soon, while the second, which should be retained as long as possible, may be medicated. The water need not be hot, but it should be more than tepid, and in quantity may be about a quart. In

case the second injection is absorbed, so much the better for the cellulitis.

These rectal injections may be repeated as the case demands. During the suppurative stage they sometimes afford great relief, and serve to hasten the formation and discharge of pus. In such cases they may be repeated two or three times in twenty-four hours.

4.—*The immoderate and the too prolonged use of hot water vaginal irrigation.*—We can not reasonably suppose that an agent, which is so powerful as hot water topically applied would not be harmful when used immoderately, or for an unlimited period and without proper discrimination. It has become the fashion for physicians to order it in a routine, off-hand way for the relief of intra-pelvic congestion; and even when the doctor may have supposed that his patient had discontinued its use, she will, perhaps, have continued it for months or for years, without the least idea that it might be harmful, and that it would almost surely increase her suffering and make her a chronic invalid. There are many cases in which this habit is responsible for the perpetuation of the pelvic mischief. It should be remembered that vaginal irrigation is useful only in the early, or the acute stage of pelvic cellulitis. In case of relapse it may be used with good effect, temporarily. If suppuration has ensued, and the pain is great and continuous, it may be conveyed *very slowly* into the vagina by means of a syphon, or a fountain syringe, for an hour or two at a time with good effect. But in the usual chronic form the best results obtainable from the hot water applications internally can be had by passing it through a common Ferguson's speculum, while the patient is in a sitz-bath.

II. REMOVAL OF AN OVARIAN TUMOR OF OVER THIRTY YEARS' GROWTH, THE TUMOR WEIGHING SIXTY-TWO POUNDS, AND THE PATIENT SEVENTY-FOUR POUNDS.—RECOVERY.—In presenting the preparation of a large ovarian tumor to the society for its inspection, Dr. Ludlam took occasion to remark that in all his experience he had not encountered a case which had such a clinical

history as the one from whom he had successfully removed this cyst. One of the points of interest was that, when the tumor was tapped, twenty-five years before, it yielded the clear, spring-water fluid described by Atlee as distinctive of the broad-ligament cyst; and, when its contents were removed at the operation, the fluid drawn off was unmistakably ovarian, syrupy, thick and chocolate colored. This fact surely tends to confirm the modern idea that Atlee's differential sign of a broad-ligament cyst can not always be depended upon.

Another item worthy of note was the age of the tumor, about which there can be no possible doubt in this particular case. Another point concerned the remarkable vascularity of the cyst-wall, as shown in the dried and injected specimen; and still another was the fact that the poor woman weighed but a very few pounds more than the tumor and its contents.

The following notes of the case were furnished by Dr. Helen S. Dunn, of Centralia, Ill., who had charge of the patient before and after the operation, and to whose intelligent care with that of the good nurse, Mrs. Keister, the recovery of our case is so largely due:

*Case.*—Mrs. R——, aged fifty-seven, first observed thirty years ago that her abdomen was increasing in size. A year after this she bore her second child, and about five years later the third one, nearly five years intervening between each of her three children. The eldest was a daughter, the last two, sons, all living to maturity.

Twenty-five years ago her physicians thought best to tap her, and drew off a clear, odorless fluid, but only obtained about one-third of what he anticipated. I have been unable to ascertain the precise amount. Since the tapping the tumor has gradually increased in size during all the intervening time.

Although she was always considered rather delicate, she has had very fair health. Except during her confinements she has never been sick in bed for more than a day at one time. A little indiscretion in diet or a little over-exertion would sometimes induce an attack of indigestion and sick headache.

There has been nothing unusual in the menstrual history. The menses were always scanty but regular. She passed the

climacteric with less than the usual inconvenience. During the past year her burden has grown more insupportable, and she had less strength with which to bear it. She went out less, and slight causes fatigued her more than usual. On the 9th of last November Dr. R. Ludlam operated upon her in the presence and with the assistance of Dr. Belle L. Reynolds, Drs. C. N. and Helen S. Dunn and Dr. J. A. Wakeman.

The patient was placed upon the table on her right side, and etherized, after which a trocar was introduced, and some forty-five or fifty pounds of a chocolate colored fluid was drawn off; then, turning her on her back, an incision was made, and, as the fluid drained away, the sac was drawn through, the pedicle ligated, canterized and dropped. The cyst was single, and with its contents weighed sixty-two pounds. (The last time our patient was weighed her weight was 136 pounds, since which time, while the tumor has grown, she has become more emaciated. But after the tumor was taken she could not have weighed more than seventy-four pounds.)

She reacted nicely from the operation. Temperature was elevated a little in the evening, and pulse accelerated. She slept most of the time the first forty-eight hours, and complained of nothing but the tiresome position, being placed on her back and with only one pillow, it being her habit to sleep on her right side and nearly upright. She began taking a little nourishment the next morning, which was gradually increased, and after the first two days the temperature and pulse dropped until the sixth day. After the use of the catheter, which had been necessary all along, she began to complain of vesical tenesmus. Thinking the catheter had caused some irritation, every measure was adopted to produce voluntary urination, the attempts being partially successful, so that the use of the catheter was delayed until into the night, when it was again passed, and a pint of urine dark and thick with blood was drawn off. The patient was greatly relieved, and the catheter had to be used every two or three hours until the evening of the seventh day, when the urine again became normal. *Nux* and *Ars.* were the remedies used. A rise in the pulse and the temperature accompanied the urinary trouble and continued, for the rectum now became the seat of occasional sharp pains with a burning sensation. The bowels were gently moved by enema the eighth day, which gave considerable but not complete relief. Examination revealed tenderness in the posterior cul-de-sac, and along the recto-vaginal septum, but we could detect no swelling. *Merc. cor.* and *Apis* were administered, with vaginal douches of hot water, and a diet largely of milk and milk-punch. A mild



diarrhoea set in, and continued until a discharge of pus from the rectum on the twentieth day wound it off. Three weeks longer the temperature ran between  $100^{\circ}$  and  $102^{\circ}$ , only a few times getting higher or lower. The pulse varied between 70 and 100, the average being about 85; tenderness and swelling coming and going in the recto-vaginal wall; the tongue thickly coated. The catheter was necessary for nearly six weeks. The abdominal wound never gave us any trouble.

The beginning of the seventh week found our patient sitting up during the day. The tongue is clear, the appetite good; she sleeps well, and is in excellent spirits. Briefly, although the convalescence was slow, she is now, much to the delight of her family and friends, quite well again.

III. LAPAROTOMY FOR TUBERCULAR PERITONITIS. REACCUMULATION OF THE ASCITIC FLUID.—Dr. Ludlam prefaced his third paper with a few remarks on the growing interest which attaches to abdominal and genital phthisis. Peritoneal surgery has opened up this new field of study, and the outcome is likely to prove of the greatest possible good to us and to our patients. Through laparotomy not only is it possible in some of these very obscure cases to arrive at an absolute diagnosis, but through this means also it has been found that a share of them are actually curable.

The following case is presented to show how impossible it sometimes is to know what the trouble is without an explorative incision, and also to prove that cases of peritoneal tuberculosis are not always materially benefited by the abdominal section. For the notes of this case he was indebted to Dr. J. H. S. Johnson, of this city, who was the patient's family physician.

*Case.*—Mrs. ———, a German, married, is of medium size, light complexion and dark hair. All of her relatives are healthy and long-lived, excepting her father, who suffered each year for many years with a disease of the throat, and finally died from the operation of tracheotomy. She has six brothers and three sisters who are all alive and well. There is no hereditary disease in her family.

She has been married eleven years; her first child is ten years old, and living. A few hours after his birth the lochia stopped suddenly, the uterus filled with water, the abdomen

enlarged enormously; she became dangerously ill, and on the ninth day the water came suddenly away. She has never felt well since that time. Within one year the second babe was born, and died; the next year, the third babe was born, and it died also. She came to this country about six years ago. She got her feet wet, and took cold about four years ago. The menses stopped for a while after coming here, and during the last four years they have been very irregular, sometimes disappearing for six or more months. They have now been suppressed for nineteen months. She suffers from severe pains in the abdomen, and during the warm season had a diarrhoea with six or seven stools each day. During the cold season she is constipated, eats heartily, often vomits, is weakly and often faints. At the time of the suffering in the abdomen the bowels seem filled with gas. She also has frequent headache.

About two years ago she suffered from symptoms of malarial fever, which lasted a week or more. The face and the lower jaw swelled enormously, but this swelling soon disappeared. Since the menses stopped she has grown rapidly worse, and she has noticed a swelling, as if a hard tumor was forming in the epigastric region. The duodenum was often distended with gas. The veins of the skin covering the whole abdomen were distended enormously until a few months ago. Eating caused terrible distress, which was partly relieved by vomiting. The urine was scanty.

During the past year she has consulted a number of leading old-school doctors. One of them said that she had an ovarian tumor; another, that she had disease of the kidneys, for which he treated her for some time. A third, who assumes to know all about gynecology, said that she was pregnant; and a fourth decided that she was suffering from cancer. Most of them advised an operation for the removal of the supposed tumor as her only hope for relief.

On Monday, October 24, 1887, the exploratory incision was made by Prof. Ludlam. There were present Drs. R. C. Bain, of the Hahnemann Hospital, R. Ludlam, Jr., and J. H. S. Johnson. The very large ascitic accumulation was removed, and the contained organs were carefully examined. There was no tumor. The reflection of peritoneum over the upper surface of both the broad ligaments, and over the corresponding side of the uterus, was studded with miliary, or *grains de riz* tubercles. These deposits were also very thickly strewn through the mesentery. The stomach was very much dilated, and its pyloric extremity had a suspicious induration which to the touch felt very much like schirrhous. The wound

was afterward cleansed and closed with antiseptic precautions.

Reaction was not very good at first, but the wound healed kindly. She had her ups and downs, at one time her temperature reached  $105^{\circ}$ , but the remedies brought it down again.

In another month, and for each of the three months since the incision was made, the tapping has had to be repeated. She is gradually running down, and can not survive very long.

IV. VARIX OF THE ANTERIOR VAGINAL COLUMNS.—H. I. OSTROM, M. D., OF NEW YORK.—Because of my failure to find any record of a similar condition, I am inclined to consider the following case quite unique in the history of tumors of the vagina.

*Case.*—Two years ago I was requested to treat Mrs. C. for a slight attack of cystitis. The disease yielded quickly to washing out the bladder with bi-carbonate of soda, and the internal use of *Chimaphila*. When passing the catheter for the purpose of irrigation, I detected a considerable enlargement of the anterior vaginal walls, just posterior to the meatus urinarius. At the earliest opportunity I made a thorough examination. The vagina was darker than usual, presenting almost the characteristic discoloration of pregnancy. The anterior vaginal column was double, or possibly it would be more accurate to say that the site of the columns was occupied by two perfectly distinct, dark purple tumors about the size of a hazel nut, that one on the left of the median line being the larger. These tumors were soft, slightly compressible, and felt quite like a varicocele. After pressing the blood out, the vessels could be seen to slowly refill and become turgid. They were in no degree sensitive, and their presence had not been suspected by the patient.

A short time after my discovery of these tumors there appeared a painful swelling of the left side of the vagina. I found a condition involving the left bulbi vagina, very similar to that which existed in the vaginal columns. The varix was well marked, and about the size of an English walnut. It was quite sensitive to touch, and rendered coition impossible. I was informed that several similar attacks had preceded this one, and that they had all passed away without treatment. This history has been confirmed by my subsequent knowledge of the case, for from the time of my first acquaintance with it to the present there has been a number of recurrences, with spontaneous cures.

By the most careful questioning, I have been unable to elicit any causes for these periodical varicose tumors. They are un-

connected with any discoverable pathology of the pelvic circulation, and do not seem to depend upon the functional activity of the reproductive organs. That there is some local predisposition is apparent from the unvarying place of recurrence, but during the period of quiescence there is nothing to indicate where the disease has been.

The varicose tumors of the vaginal columns have gradually increased in size since I first observed them, but they still give no inconvenience. Possibly they contain erectile tissue, for I have observed, while making applications to the vault of the vagina, that they become turgid when touched. I have proposed removing them with the *écraseur*, for, at the present rate of growth, they will, before long, attain such a size as to interfere with the function of the vagina. In addition, there is the risk of bursting, and, as a result, dangerous hemorrhage; but the consent of the patient has not yet been obtained to operate for something which causes no inconvenience. Should she become pregnant, a condition for which she is anxious, I think it more than probable that during parturition the distended walls of those tumors would yield, and the hemorrhage be difficult to control.

The etiology of this case of varicose enlargement of the anterior vaginal columns is obscure. The patient has been twice married. Her only child was born during the lifetime of her first husband. I am told that the labor was a severe one, and greatly prolonged; she was attended by a country practitioner, and sustained quite a severe laceration of the cervix, and a lower laceration of the perineum, neither of which, at the time she came under my observation, were of sufficient moment to require operative interference.

Possibly we are here dealing with a class of causes similar to those which are believed to influence the development of cysts in the anterior vaginal wall—irritation. I am the more inclined to this opinion, from the fact that I think this patient's sexual nature an unusually strong one; and were this not true, her absorbing desire to bear children would lead to a more frequent repetition of the sexual act than feelings alone dictated.

On the other hand, the condition may be congenital, and this hypothesis is strengthened by the evident erectile character of the tissue of which the tumors are composed.

V. MASSAGE IN HYSTERICAL COXALGIA. TRANSLATED FROM JOUSSET'S CLINICAL LECTURES.—BY DR. R. LUDLAM, JR.—Hysterical coxalgia is an extremely rare affection, the history of which is far from being complete. Frederic Hoffman was the first to call attention to it. He speaks of an hysterical subject "who suffered from intolerable pains in the left foot, the thigh and in the hip, which prevented her walking."

Brodie has treated arthralgia more especially in hysterical subjects, and also of coxalgia, but his cases are drawn from the surgeons. Lesauvage, Robert, Gosselin and Verneuil have thrown much light upon the pathology of this disorder. The diagnosis of hysterical coxalgia is often extremely difficult, and Bonnet himself has been mistaken. In the following case an error in diagnosis was made by a very distinguished military surgeon.

*Case.*—Miss D., aged fifteen, daughter of a gouty father and a hysterical and tuberculous mother, is a brunette, well developed and of a good complexion. The menses appeared very early and very copiously, and she had already had several hysterical attacks. During the summer of 1877, after a season at the sea-shore, she was seized with acute articular rheumatism, for which she received some treatment. When I saw her in November her condition was as follows: the febrile symptoms had disappeared, but some of the joints still remained painful. The coxo-femoral articulation with the knee and ankle joint of the left side, also the knee and ankle of the right side were especially involved.

Pain is the most prominent symptom, being at times so severe as to prevent sleep. These joint affections are accompanied by slight redness, but no swelling; they are movable, being at times more pronounced in one or another of the joints already named. From this time they assumed a singular phase; they are accompanied by a marked extension of the limbs caused by an almost invincible contracture of the extensor muscles in whichever limb the pain is located. Now, we know that in rheumatic and scrofulous joint diseases the parts most often become fixed in a state of demi-flexion. In this case the immobility was more marked than in other joint affections, and in an extreme state of extension, which continued day and night. This condition lasted during the winter, with more or less pain, violent and continual gastralgia, loss of appetite, frequent headache, some nervous spasms of a non-convulsive kind, incomplete analgesia; the menses came regularly, but were always very abundant. There was neither any general nor local emaciation of the patient.

These conditions resisted the apparently indicated remedies, which produced only slight and temporary relief. Being anxious concerning the case, I asked the advice of one of the college professors, who thought that the rheumatic period of the affection was passed, and that we had a case of *hysterical joint affection*; he also thought that the marked extension of the limbs, which had lasted several months, would cause some serious results, and advised relieving them as soon as possible.

The young girl was chloroformed, and the lower limbs were put through the movements of extension and flexion, which proved the absolute integrity of the joint. These same movements, without an anaesthetic, accompanied by massage, were practiced on the ensuing days, and great improvement resulted from this treatment, which was too soon discontinued. Afterward the patient was able to flex all the joints of the lower limbs; the pains became localized in the joints of the left limb, and, little by little, we saw the coxalgic symptoms appear. At this time an army surgeon did not hesitate to say that we had been mistaken in our diagnosis, and that it was necessary to put the patient in a splint, and caries of the bones and abscesses could hardly be avoided. This advice was given without hesitation, and we proposed another consultation to the family. Two surgeons were called in, and they recognized it as a case of hysterical coxalgia. During the summer of 1878 the patient resided at Bourbonne, where she felt much better, being able to walk, and even dance, although limping slightly, and still complaining of some pain in the hip. On her return, at the beginning of winter, she complained as follows:

Pain in the left hip, thigh and knee, which is increased by the least motion or pressure. There are points where it is severe, and where it is increased, not by deep pressure, but by mere contact. At these points there is a real cutaneous hyperaesthesia. The most painful points are found on the crest of the ilium, and in the left ovarian region; pressure made on the great trochanter, on the contrary, causes no pain. The muscles of the hip draw the head of the femur into the cotyloid cavity, producing an apparent shortening of ten centimetres (four inches) immobilizing the limb in a state of adduction with rotation inward. The position is precisely that of genuine coxalgia.

When she attempts to walk her lameness is peculiar: instead of walking with a stiffness peculiar to coxalgia she moves with a marked lameness which bends the entire body to the left side, as though she were endeavoring to touch the floor with her hand, and this movement is like a salutation. There was no local emaciation, both thighs being of the same dimensions. Her general health was fair, no fever, but always complaining of gastralgia and headache, a marked depression, and a somewhat nervous condition. This continued during the entire winter, with slight improvement at times, but without any material change. Electricity, metallotherapy, injections of morphine, sulphur and arsenic baths had no marked beneficial effect.

The principal surgeons in Paris, again consulted, agreed to the former diagnosis of hysterical coxalgia. However, the persistence of the deformity, the long duration of the affection made

the last surgeon undecided, and he proposed to anæsthetize the patient again, and to make a most thorough examination of the hip-joint, because of the muscular contractions and excessive pain which made a careful examination impossible without it. She absolutely refused her consent, and it was impossible to overcome her determination not to take chloroform. It was then that I called Dr. Le Bastard, whose skill was well known.

From the first application of massage Dr. Le Bastard was able to overcome the contracture, and to restore the limb to its natural position, so the treatment was given every day, and the improvement was slow but continuous. At the end of some weeks the pains were very slight, and she was able to walk with little lameness. Salt water baths were taken during the summer, and her general health became good; nevertheless the pains in the hip and slight returns of the muscular contractions made it necessary to have frequent massage. The cure was not entirely effected until some eighteen months after Dr. Le Bastard's first visit. A season at Bourboune and its waters assisted greatly in the cure.

The diagnosis of hysterical coxalgia rested on the following points: the nature of the pain, the form of the lameness, the absence of fever and emaciation of the thigh, and the possibility of removing the deformity, either under anæsthesia or by massage. As to the signs of heredity or similar conditions, they are of little value. Our patient was consumptive, and had, at the commencement, an attack of acute articular rheumatism. She was, therefore, in a favorable condition for an attack of scrofulous or rheumatic coxalgia. It is true that she was hysterical, but how many hysterical subjects are both scrofulous and consumptive.

*Signs drawn from pains.*—In scrofulous coxalgia the pain is dull, deep-seated, and only becomes pronounced after fatigue or injury to the affected joint. In all cases it remains deep-seated. In hysterical coxalgia the pain is acute, superficial, and, like hysterical hyperæsthesia, is increased by the slightest contact. It is not seated in the joint, but along the course of the nerve tract, and in the ovarian region. It is more marked during the day, although this is not always the case.

*Signs drawn from the lameness.*—The lameness in the scrofu-

lous form depends upon stiffness of the limb, which is thrown to one side in extending it, and hobbles when drawing it up. He instinctively immobilizes the affected joint as much as possible, and moves the hip and thigh as though they were one. The unequal steps are easily seen, and more easily heard; the patient rests more strongly and for a longer time on the well limb than on the lame one. This symptom is occasioned by the pain in the hip which comes from the contact of the foot with the ground or the floor.

In the hysterical variety the lameness is irregular; the muscular movements of the affected muscles are exaggerated, and often resemble a profound salutation, a sort of dance.

*Signs from emaciation of the thighs.*—This is always constant in far advanced scrofulous coxalgia, but is always absent in the hysterical form.

*Signs from fever.*—Fever never exists in hysterical coxalgia when it is chronic; but it is present in old cases of scrofulous coxalgia.

*Signs from the deformity.*—The disappearance of the deformity of the limb under chloroform or by massage is certain in the hysterical subjects, as we have seen in the above case. In the scrofulous form this result is never obtained.

In conclusion, the diagnosis of hysterical coxalgia is easy, but on condition that we are not misled by the deformity of the limb or the obstinate nature of the disease.

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The report of the *Calcutta Homœopathic Charitable Dispensary* for the year 1887 is a very creditable pamphlet, and is clinical in its way, by reporting many cases of cure with remedies that are quite unknown to us. Chronic diarrhœa with *Aegle marmelos*; urinary phosphatic calculus, with *Ficus Indica*; mercurial absorption, with *Hemidesmos Indicus*. We congratulate the charitable donor through whose generosity all this is possible in the good work he is doing.



## Book Reviews.

*The Twelve Tissue Remedies of Schussler*, comprising the theory, therapeutical application, materia medica, and a complete repertory of these remedies. Arranged and compiled by WILLIAM BOERICKE, M. D., Prof., etc., and WILLIS A. DEWEY, M. D., Prof., etc. Philadelphia, F. E. Boericke, Hahnemann Publishing House, 1888. 8vo cloth, \$2.50.

It accords with the fitness of things that this book should be noticed in a clinical journal. Its table of contents not only treats of the technical materia medica of the twelve tissue remedies, but also of their therapeutical application. It is a book for practical use, and not for dress parade. Its keynote is clinical, and it abounds with hints and helps for those who have not yet put these remedies to the test, as well as with confirmations of experience on the part of those of us who have used them, and who are supposed to know something of their real value. In its time (and it is a pity that its time has passed), there was another book which set forth the merits of about a dozen chosen remedies in such a way that the earnest physician could avail himself of them with a measure of intelligence and satisfaction. That book was *Hartmann's Ten Principal Remedies*, translated by the gifted Okie, and it did more to establish the faith and the practice of some of our best physicians than any other work of its size. It is great praise to say that this edition of Schussler's book is in a similar vein, and that in our opinion it will prove of corresponding service to the profession. In its English dress it is budded here and there with fanciful ideas that will doubtless drop off in another edition, and backed up with occasional quotations from unreliable sources—a thing which it is, perhaps, impossible to avoid.

The repertory adds very much to the value of this edition of Schussler's book. It consists of nearly a hundred pages, and is very thorough and satisfactory. The bio-chemical considerations, based upon the fact that the twelve tissue salts are constituents of many of our better known remedies, and that their symptoms are the necessary counterpart of such as are found in the provings of Pulsatilla, Baptisia, Phytolacca, Gelsemium, etc., will interest those who like to inquire into the reason of things. Briefly, we especially commend this

publication to those who have the care of a class of chronic and difficult cases which can not be disposed of by any of the modern cure-alls that are so much in vogue.

*Specific Medication and Specific Medicines*, by JOHN M. SCUDDER, M. D., Prof. of the Principles and Practice of Medicine in the Eclectic Medical Institute, etc., etc. Eleventh edition; Cincinnati, Wilstach, Baldwin & Co., 1884. Pp. 432

There are other words beside wealth and wisdom, health and happiness, that have a relative meaning. Professionally speaking, the terms specific medication and specific medicines should only be used in the comparative or relative sense. The author has kept this idea in mind, and has turned the full force of his logic and experience to refute the old saw which holds that "there are no specifics in medicine." He says:

"Specific medicine requires specific diagnosis. We do not propose to teach that single remedies are opposed to diseases according to our present nosology. These consist of an association of functional and structural lesions, varying in degree and combination at different times, very rarely the same in any two cases. To prescribe remedies rationally, we are required to analyze the disease and separate it into its component elements, and for this we select the appropriate remedy."

The first fifty pages are devoted to brief chapters on The Theory of Specific Medication; Specific Diagnosis; Difference from Homoeopathy; The Administration, Form, Dose, Preparation and Classification of Remedies. Then follow 200 pages of brief notes on special remedies—a sort of a go-as-you-please materia medica, with a long appendix; and thereby hangs a tale, for the best part of the book is in the post-script, which consists of a reprint of various practical papers that are well worth the reading. The consideration of such subjects as the Elements of Uncertainty and of Certainty in Medicine; the Doctrine of Substitution; a Single Remedy; Pain and Its Treatment, and the Conservation of Life, is very suggestive, and cannot fail to do real missionary work among those who have never read Hughes, or Dunham, or any of the more practical writers of our own particular school. These papers have given the book its merited popularity, and carried it through eleven editions already. Not only is it the best of the author's many productions, but it is, in our judgment at least, the best of all the works on therapeutics that have emanated from the eclectic press.

## Miscellaneous Items.

This issue has been unavoidably delayed by the printers. —Dr. J. Watry has been assigned to duty as clinical professor of the diseases of the eye and ear in the Hahnemann Hospital. —Dr. B. S. Arnulphy has changed his residence to 344 La Salle Avenue. —Dr. Belle L. Reynolds has been re-elected, for the fourth time, to the medical charge of the Chicago Home for the Friendless. —Dr. F. S. Worcester has located in Newburyport, Mass., of which burgh he is city physician and president of the board of health. —Dr. F. E. Boericke, publisher, sends us a brace of new books which are noticed elsewhere. —Dr. Chas. A. Bacon has removed from New York to 1312 Connecticut Avenue, Washington, D. C. —We regret to note the sudden death, from apoplexy, of our old friend, Dr. George Fellows, at Waukesha, Wis. He was the esteemed father of Dr. C. G. Fellows, of New Orleans, La. —The transactions of the State Homœopathic Medical Societies of Wisconsin and Pennsylvania for 1887 are thankfully received. —Prof. A. K. Crawford, who has been very ill in California, is recovering. —Prof. Hoyne entertained the class a few evenings since with a popular lecture on his foreign travels; and Prof. Bailey gave one also upon his own observations while visiting the laboratory of the celebrated Pasteur, in Paris. —The alumni of the "Old Hahnemann" are arriving to help us through with the commencement season. —The *Medical Advance* is now being published in this city, and already looks the better for the change of climate. Bro. Allen is still in editorial charge of it. —The prospect for the post-graduate course, which is to follow the winter term, is unusually good, with an overflow of clinical material. —Prof. King will report for the bureau of skin and venereal diseases at the March meeting of the Clinical Society. —Arrangements have been made for the addition of a review department in future issues of *THE CLINIQUE*. —Prof. Fellows will furnish the clinical lecture for our March number.

# THE CLINIQUE.

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[No. 3.

## Original Lectures.

### *BRAIN DEGENERATION. BRAIN IRRITATION FROM SHOCK, SPINAL IRRITATION AND NER- VOUS PROSTRATION.*

A CLINICAL LECTURE DELIVERED BY PROF. H. B. FELLOWS, M. D.,  
FEBRUARY 27, 1888, IN THE NEUROLOGICAL CLINIC OF HAHNE-  
MANN HOSPITAL, CHICAGO.

*Case 15232.*—DEGENERATION OF THE BRAIN.—Mr. W., aged forty-seven years. Patient first complained of headache July 4, 1887, which returned at subsequent times. On September 1, he came home and told of falling asleep in his buggy, waking up suddenly, and not knowing where he was. His wife noticed that he was disposed to sleep far more than usual. Falling asleep in the cars, he would be carried past his home. There was also at this time a loss of ambition. September 1, he had in his wife's presence the first of what were called "congestive attacks." He was assisting her at the time, and, having a number of articles in his hands, asked what he should do with them; she, not understanding, inquired what he said, when he again attempted to ask the question, but could not articulate the words. Going to where he was standing with the articles still in his hand, she found him with face very pale and hand very cold; she led him to a chair and inquired what ailed him. He sat motionless fully ten minutes before he could answer, and then said he could not help it.

The second attack was three weeks later and similar, but more severe. In neither of these attacks was there loss of consciousness or of muscular power: but the third attack, occurring three weeks later, was more severe, and with it there was unconsciousness and loss of muscular power in the

left hand and arm. It was following this third attack that he had what was called congestion of the brain, and was sick for three weeks. For one week he was considered dangerously sick. During this sickness he had these attacks every three or four days, the attacks increasing in severity, there being unconsciousness and loss of muscular power in the hand and arm. The duration of the first attack was fully ten minutes. The latter were thirty to forty-five minutes in length; lately they are less severe and shorter. The trouble now begins in the left arm and hand, which become cold and powerless, the right one retaining its power and normal temperature. They become swollen, and the body bloats a good deal in the epigastric region. The face is sometimes red, sometimes very pale, and becomes puffed and the tongue swollen.

During these attacks the patient is completely unconscious. The left arm remains useless for about thirty minutes and must be moved by the right hand. The memory is failing quite rapidly. Sometimes the patient talks fairly well, and again will stop in the middle of a sentence, forgetting entirely what he wished to say. In rising from a sitting posture he is very apt to stagger. He drags his feet in walking and shows a tendency to stagger to one side. He is troubled between attacks about recognizing people—even "the old familiar faces"—and frequently does not realize where he is.

Up to the time of the first attack he was apparently in perfect health, except for the left eye, the visual field of which is very much narrowed, less than a quadrant of vision remaining. This defect of vision he traces to an injury received during the war from the shock occasioned by the passing of a shell near that side of the head. The sensation of touch is blunted in the hand, although there is no anæsthesia. The grip of the right hand, as measured by the dynamometer, is, 1st, 155; 2d, 125; 3d, 140; of the left is, 1st, 100; 2d, 110; 3d, 90.

The general condition of the patient is very good; he eats and sleeps well; bowels regular. He suffers, however, from an almost daily headache, which is worse mornings. The muscles, especially those of the left side, jerk and twitch during sleep. The face loses all expression during the attacks, but his wife thinks it is not drawn.

This case presents some points of special interest worthy of study. It is evident there is a decline here of both physical and mental power. The decline in mental power is shown especially by the loss of memory and of ambition. The de-

fect of memory is shown by the inability, from time to time, to recognize familiar faces, and, as the wife says, by forgetfulness of recent events. The memory for events further in the past, however, seems comparatively good; and he describes, with a fair degree of accuracy, the injury received in the army, the recovery from it, and the experiences attending it. Thus, he definitely refers the injury to the sight to that time, or about that time, describing the circumstances under which he discovered the imperfect vision of the left eye in sufficient detail to warrant us in believing his description correct.

It also enables us to come to the conclusion that the defective vision so far antedates these recent symptoms as not necessarily to be directly connected with them. The ophthalmoscopic examination of the fundus of the eyes proves the right eye to be very nearly or quite normal; while the left eye shows much pigmentation of the retina, and the remains of what I judge to be former disease of the choroid. It was very difficult to get a satisfactory view of the fundus, owing to the impossibility of securing a fixation of the eye, the patient being apparently unable to exert continuous control over it, which, however, in this instance, is unimportant at this time, because the disease of the eye was undoubtedly caused by the injury to it during the war, and from the fact that so long a period of good health has intervened between the first impairment of sight and the more recent symptoms.

The treacherous condition of the memory is further indicated by the patient forgetting the subject of his conversation in the midst of the sentence, showing how imperfectly the brain is acting, and how it has fallen away from its original vigor. This, indeed, may be one of the facts that will explain to us the loss of ambition, for the mind acts not in a continuous and logical, but in a spasmodic and weakened manner. For instance, subjects formerly wont to arouse and fix his attention, holding it steadily to the point, effecting a co-ordination of all the mental processes, and thus producing regular and systematic brain action, are now ineffectual to urge the will power to vigorous action, and thus hold the attention.

Our conclusion must be that what would be a sufficient stimulus to produce in the patient the usual desire and consequent action—in short, the will power—has failed. The result is that the ordinary desires of life exert but a momentary effect on the brain, and life becomes but aimless existence. If these diseased processes are suffered to go on, a gradual decline must supervene, even until mental activity be submerged, and only the animal remains. There has already been deterioration in the physical as well as in the mental condition, as indicated by the lack of strength in the left side, as shown by the dynamometer, the dragging feet, and the sidelong stagger.

There is evidently inability to perfectly co-ordinate motion; and the fact that one side shows chief loss of power, and that the whole side is affected, indicates that the difficulty is seated in the brain, at least mainly, and more in the right side than in the left.

It is now pertinent for us to inquire as to the nature of this diseased process. Popularly, softening of the brain is applied to almost any condition in which there is a gradual loss of mental power; but technically the term is limited. There are various conditions in which there is loss of mental capacity without any softening of the brain appearing post mortem, but where embolism, thrombosis or hemorrhage occurs we are apt to find softened brain tissue, though softening does sometimes take place when these accidents cannot be demonstrated as an accompaniment of it. There may be a sufficient change in the nerve cells of the brain to cause loss of mental action, or of motor action, or anæsthesia, and still no softened areas be found. In order to form a conclusion as to what process has been going on in this brain we must go back in the history of the case to its beginning, and study somewhat the mode of onset.

Had embolism caused these symptoms they would have come on with greater suddenness. Here they came on slowly, notwithstanding that certain more acute conditions have sprung up from time to time. Had a thrombosis caused paralysis so completely as takes place here at times during the more acute

attacks, the paralysis would have proved more permanent. The same would be true of a cerebral hemorrhage; and none of them would be apt to repeat themselves in this way so frequently.

We may, therefore, conclude that none of these last mentioned diseased processes underlie the beginning of this case. On the other hand, the sleepiness, the loss of ambition, the forgetfulness, coming up gradually, show some disease which, while it tends to destroy the action of the nerve cells, is slow in its development. This may involve or even start in some way from the blood vessels, but must be in nature more of a chronic degeneration; or it may start from the brain tissue itself.

The acute attacks are not at all unusual in such a pathological condition. As an instance, we see them in epilepsy as complete as they are here; in fact this sudden loss of consciousness would seem to partake of the epileptoid nature. But epilepsy, pure and simple, would not leave the paresis of one side so continuous.

We conclude then that here some chronic degeneration is going on within the brain tissue, but it is perhaps impossible to tell at the present stage, with certainty, its exact nature. We are, at least with the limited time we have had for study of it, unable to characterize it with more of certainty. There may possibly be a growth forming in some part of the brain which has produced this degeneration of tissue, but as yet the symptoms do not warrant us in the conclusion that any tumor is forming there. The daily headache is not confined to conditions in which tumor is present, but is frequently a marked symptom in general paresis and in softening. The swelling of the tongue and hands, and the bloating of the stomach, are probably due to cerebral irritation, causing a temporary paralysis of the vaso-motor nerves of these parts, and producing this puffiness.

That the cause is not local is shown by its being as temporary as the other symptoms which accompany it. It seems to be preceded by an irritated condition of these centres, as shown by the coldness and palor of the face and extremities, which is



followed, apparently, by their exhausted condition, causing their non action and allowing undue expansion of the vessels. We must, therefore, leave the differential diagnosis until such symptoms develop as may enable us to discriminate the case more closely than merely as one of brain degeneration.

The prognosis of all this class of cases is not very bright; still we can not say they are hopeless, for some of them, with symptoms as well marked as we find here, do make recoveries, the degenerative process not having passed beyond the reach of remedial measures. We need not, therefore, doom these cases to hopelessness, although it is true that, viewed from a statistical standpoint, a large percentage prove refractory to treatment.

We will give this patient *Arg. nit.*, 6, four times a day.

We are indebted to the courtesy of Dr. E. Z. Bacon for the opportunity we have had to-day of studying this very interesting case.

[March 7, 1887. The patient went into the country, and the reports from him indicate improvement. He has had but one "bad turn" since.]

**BRAIN IRRITATION FROM SHOCK.**—*Case 15230.*—Clarence W., aged ten years. Five years ago the patient had a fall on the ice, striking the back of his head. The fall was followed by a severe headache which lasted a few minutes, then disappeared to again return. These attacks come more rarely now, but he is still troubled every few weeks with dizziness and headache, during which he vomits a good deal. The attacks of vomiting come on suddenly and without nausea, and the matter discharged is of a slimy and watery nature. He is very restless in sleep, and can not see distinctly with the left eye. Base of occiput still tender to pressure.

This is a case of nervous shock, affecting more particularly the base of the brain. It is very unusual for a child as young as this one was when he had the fall, to suffer much from headaches unless there is some cause located within the cranium. In children of his age, and those younger, it is never safe to pass headaches by as of no consequence.

They are often signals of warning held out to indicate serious mischief within the head. In this case the headache

seems directly traceable to the blow on the head received in the fall, and although the skull was not fractured, and there is no scar to indicate any injury of the scalp, the blow has still produced a considerable degree of irritation. There may be no organic change within the cranium at this point, at least none so coarse enough to be detected by a post mortem examination, but there is a condition of serious irritation. It is probably like the irritation of the spine that originates from railway shocks, the condition which has been denominated a railway spine, and in which, often, after years of suffering, no coarse, organic change can be found. Still it can not be predicated of any such case in the beginning that organic change will not take place.

So, too, we find that after blows on the head, producing shock of the brain, organic change may in time follow. In either case, however, we can not designate the condition more closely than to say it is a state of irritation. In the case we are considering, the constant return of this pain, and the tenderness in the region affected, show that here there has never been a recovery.

Often during the periods when the head is free from pain, it is only necessary that the parts be irritated from some cause without, to reproduce the pain and distress. The vomiting is undoubtedly caused by the irritation of the pneumogastric nerve at its root. It will be noticed that it comes without previous nausea and is sudden, in fact, such as is described as cerebral vomiting. As there are no positive symptoms in this case of organic disease having as yet taken place within the brain, we may hope for a complete cure, yet to produce it will probably take time, and it may be necessary for months of treatment to be given before these headaches will be mastered, and the irritated parts to have regained sufficient strength to enable them to bear the ordinary wear and tear of life without these resulting paroxysms of distress.

This boy was given *Hypericum*, and improvement reported. He has, however, had a return of the symptoms and we will change him on to *Silecea* 6, three times a day. This remedy has done me excellent service both in this class of occipital

headaches and where there have been shocks from blows on the spine.

SPINAL IRRITATION AND NERVOUS PROSTRATION. — *Case 15213.* — Miss M., aged twenty-five. When about thirteen years old, a severe pain began in the lower cervical region of the spine, and has greatly extended, until now it reaches the lower dorsal region. During the first attack, which came without apparent cause, she had "strong symptoms of paralysis," and even now the hands and feet become occasionally quite numb. Three years ago the spine became very sensitive to touch, and is so yet. At that time she noticed a severe burning pain in the stomach which has remained more or less irritable ever since. She has always been troubled with indigestion, and is naturally weakly. The symptoms of paralysis were confined to the left side, the numbness and tingling being well marked. These sensations come and go, have never been constant. She has occasional attacks of dizziness, and is troubled quite frequently with severe headaches, which seem to begin in the spine and run to the forehead. All general symptoms are aggravated at the time of the menstrual flow, which is too early and too profuse and lasts from six to nine days, and is accompanied by considerable pain. The patient is very easily excited and is apt to be "blue." Bowels irregular, most frequently costive; at times diarrhoea; appetite poor; sleep not restful; condition anæmic; pulse somewhat irregular and rapid.

This is one of a type of cases of broken down nervous constitution which are too frequently met with. The symptoms affect so many different organs, and in such ways, that it is often difficult to say exactly in what one the condition originated. We have here a tender spine, which seems to date back to the beginning of the difficulty. The severe pain which was described as the beginning was said to have come without any apparent cause. Probably if we could get an accurate history of the state of the patient at that time we would be able to trace a cause; but this is now lost in the obscurity of the past. General ill health, indigestion, poor nutrition, thin blood, more or less menorrhagia, variable nervous symptoms, with headache and depression of spirits have followed this case until we have now a constant state of chronic invalidism.

Notwithstanding the patient says there were "strong symptoms of paralysis," there is nothing to show that organic

change has taken place either in the spinal cord or in the brain. It is a fact, however, that such symptoms of paralysis as numbness and tingling of the extremities of one side or the other, or both, frequently occur in this class of cases, and sometimes there is even a degree of motor paralysis, and yet, the whole may belong to the functional class of symptoms. We have here, in the tenderness of the spine, a distinct symptom of what is called spinal irritation.

It may be a question here, and certainly it is one in many of these cases, whether this is but one of the symptoms of the general condition. But whether we consider it as neurasthenia, or hysteria, or spinal irritation, certain it is that it is often quite impossible to draw a distinct dividing line between these various conditions, for symptoms which are usually accounted to belong to any one of the conditions often appear in the others. Poor nutrition, and consequently poor blood, starving the nerve centres, in a patient of neurotic constitution, will develop a host of nervous symptoms; on the other hand, disturbed action of nerve centres is quite capable of deranging the nutritive processes of the system; and thus the two conditions form the halves of a vicious circle. Both of these classes of symptoms exist in this case, and no doubt each aggravates the other, and all in turn are aggravated by the unnatural loss of blood through menorrhagia.

One symptom in particular I wish to call your special attention to, as it shows profound disturbance of the sympathetic system of nerves, and that is the rapid, irregular and easily compressible pulse. It has been my observation that where this symptom occurs in this class of cases the cure is a tedious matter. The patients seem especially liable to relapses, brought on by seemingly trifling causes. Where we cannot put the patient under ideal hygienic conditions it becomes almost impossible, no matter what foresight we exercise, to avoid causes of relapse. They come from unexpected quarters. Some officious friend conveys a bit of bad news or discusses some irritating phase of her life; a wakeful night follows, and the next day we again hear the tale of more prostration. Symptoms that we had fondly hoped were banished

return, and, like Banquo's ghost, will not down again at our bidding. Thus, week after week may pass until invalid and doctor both have their patience exhausted.

This case, which has been coming to the clinic for some weeks, shows us this history of reported improvement alternating with loss of the gain. I do not wish to be understood as saying, however, that these cases are incurable, for many of them do regain health and a sufficient reserve of banking capital of strength to meet the requirements of ordinary life. Still, there are those that settle into chronic invalidism—already this case has suffered for twelve years—and with a host of neurasthenic and hysterical symptoms carry on the heavy burden of life from year to year. In treating them we must take the broadest possible view of the pathology. All hygienic conditions, mental and moral, must be reviewed and brought to the highest standard practicable in the specific instance. It is often impossible to remove the causes of worry, frequently one of the worst elements in the case, and to produce that mental quietude, almost absolutely necessary for their recovery. Monotony, lack of interest outside of self, anxiety and care, depress both the mental and physical system so that the best chosen remedy will have but slight curative effect. Nutrition suffers with the deranged digestion, which until it improves, gives the patient no chance to make the strength with which to fight life's battles. When to this is added that which often originates in these conditions, a menorrhagia, draining away before the month is out the little strength that may be gained, it is apparent that here is enough of the malign on which to exercise our broadest knowledge.

Because of the aggravation of the symptoms of the back and stomach, the burning in the stomach, and the character of the diarrhoea, we will prescribe to-day *Ars. 3*, four times a day.

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## Clinical Society Transactions.

JOSEPH P. COBB, M. D., SECRETARY.

The regular monthly session of the Clinical Society was held at the Grand Pacific Hotel, on Saturday evening, March 3. Dr. J. D. Craig, vice-president, in the chair. Thirty members and a large number of visitors were in attendance. The report of the evening was submitted by

*THE BUREAU OF DISEASES OF THE SKIN.*

DR. J. B. S. KING, CHAIRMAN.

This report consisted of the following papers:

I. A FEW NOTES FROM THE SKIN AND VENEREAL CLINIC OF THE HAHNEMANN HOSPITAL—By DR. J. B. S. KING.—The usual difficulty with out-patients, *i. e.*, that they seldom display enough gratitude or interest to report the final result of the treatment, was not absent from this clinic.

Very frequently the report shows gradual and continuous improvement up to a point near recovery, and then ceases; in others there seems to be a fluctuation of better and worse, with a general advance, on the whole, toward improvement, and then the report drops off, leaving the record in an unsatisfactory condition from which little or nothing can be learned.

It was found, as a general rule, that judicious local applications facilitated the cure. Whether their beneficial action was due to a curative effect or whether they simply prevented irritation, the *bete noir* of skin diseases, is hard to say.

As an instance of the benefit of local applications, I cite

*Case 13388.*—*Eczema of the Face of Twelve Years' Standing.*—Miss J. P. Originally pustular in character, now erythematous. The skin from chin to within an inch of the eyes is red, infiltrated, slightly thickened, dry, with some slight scaliness and occasional crusts and excoriations. Much burning and itching.

A year's homœopathic treatment had done very little for the skin lesion, although her general health had been greatly improved by the cessation of headaches, chronic cough, and some menstrual symptoms.

About the first of the year she was put upon *Sulphur*, a remedy that had frequently been given before, and, in addition, *Zinc ointment*, to which had been added a very small proportion of carbolic acid, was applied every night, and carefully washed off in the morning. The itching and especially the burning was relieved immediately.

At the present time the skin presents a normal appearance around the mouth and for quite a little distance on the left cheek, and this improvement is very slowly but very steadily increasing.

As *Sulphur* had been given before without this organic improvement, it is only fair to ascribe it to the action, whether curative or merely protective, of the ointment.

As a local application olive oil was found of vast benefit in dirty and neglected cases of eczema capitis of children. In these cases the hair is matted together by an unpleasant combination of thick crusts and dirt, which it is very beneficial to the child to remove. A liberal application of oil at night and a gentle removal of the softened crusts in the morning, followed by soap and water, wrought a more wondrous transformation than any internal remedy could possibly have done in twenty times that period, and that which suggested *Lycopodium* or *Mezereum* at night, proved to be more like *Graphites* or *Hepar sulph.* in the morning, the thick dry crusts being replaced by a honey-like, or a purulent fluid.

In most acute cases local applications were not used at all, and frequently the improvement was rapid, as in

*Case 13470.*—William D., four years old; large, roundish scabs of unusual thickness, with red, inflamed patches on hands, face, and back of neck; duration six weeks.

They began as little red lumps like mosquito bites, which soon filled up with pus, increasing in size and becoming covered with crusts. The teeth presented evidences of hereditary syphilis, and the patient also suffered with urinary incontinence.

October 22.—*Rhus tox.* was prescribed, and by November 1 the patient presented a sound skin and no sign of ill health.

In syphilitic affections experience seems to favor the use of the lower potencies rather than the higher. This was especially noticeable in the following case:

*Case.*—Mrs. P. Syphilitic ulcer on anterior surface of thigh, just above knee. The lesion was about two and one-half inches in diameter, irregularly roundish, the bottom of an unhealthy, grayish appearance, the edges red, ragged, easily bleeding. It was spreading gradually.

*Nitric acid 6* was given internally, and the same in aqueous dilution applied locally, with good effect. Finding my nitric acid bottle empty at one of my visits, I procured some chemically pure acid at a drug store and diluted it with water to about the second decimal dilution, and administered as before. The result was astonishingly rapid; the ulcer began to take on a healthy appearance, and to decrease in size remarkably.

When almost healed, as an experiment, I changed to a placebo. The healing process continued for about a day, then came to a standstill, and the lady remarked how difficult it was to heal the sore entirely. In a few days more it began to spread again. *Nitric acid 30* seemed to have no perceptible effect, but the second again produced a rapid amelioration, which was continued until the ulcer was completely healed.

The case is worthy of notice, for it is seldom that a medicinal effect can be so clearly and decisively traced to the remedy used and to a certain strength of that remedy.

II.—CLINICAL NOTES ON SKIN AFFECTIONS.—BY DR. W. S. GEE.—The recent developments in the study of dermatology pointing to the nervous origin of many of the most obstinate diseases, is of special interest to the homœopathic physician. To account for the curative action of his infinitesimal doses in diseases which have been treated for hundreds of years with the most powerful suppressive applications, with the greater success of the remedy selected on the law of the similars, has led to much study, with profit in other directions, but the



problem has not been solved to the satisfaction of the skeptical mind.

Hahnemann says: "The highest aim of healing is the speedy, gentle and permanent restitution of health, or alleviation and obliteration of disease in its entire extent, in the shortest, most reliable, and safest manner, according to clearly intelligible reasons." In no class of diseases is there a greater need to recall this entire section, than in the treatment of those having a pronounced manifestation on the skin.

The study of these diseases led him into the great field of chronic diseases, their causes and treatment. The varying phenomena observed by him, and the alternating states produced by drugs, led him to investigate whether certain drugs producing changes in the course of these diseases might not be acting upon a law which would enable him, if utilized, to more effectually remove the cause of the disease.

The appearance of an eruption was not the entire disease to him, but was one symptom, which, with the accompanying or alternating symptoms, made a totality to be removed by that drug which was capable of developing a corresponding similar totality.

The busy physician and hasty prescriber is too likely to pass lightly the "suppression" idea, and to "take the chances" of any bad result following.

The conscientious physician will do for other patients as he would for his own child. Do we treat these skin eruptions as though the patients were our children? Who has not seen the result of a delayed eruption in scarlet fever, or measles? If the effect is so decided and immediate in these acute diseases, may there not be as decided effect in chronic diseases, but of more remote relationship? Have we not seen the appearance of an itch eruption when treating cases of chronic diarrhoea, or of neuralgia, or asthma? and have noticed that the chronic malady disappeared in proportion to the development of the eruption?

Careful inquiry develops the fact that in previous years the patient was afflicted with an eruption, which was "cured" as if by "magic," but in a short time the more distressing

disease made its appearance. "Permanent restitution of health," and the treatment which causes the disappearance of the eruption "in the shortest" time are not synonymous. Better follow the latter part of the section, "most reliable, and safest manner, according to clearly intelligible reasons." As in the treatment of all diseases, two classes of symptoms must be considered in the treatment of skin affections: predisposing and exciting.

Heredity plays a large part in furnishing the foundation for the diseases of the infant, and kind nature seeks to protect the life of the patient by throwing the manifestation where the life is endangered the least. The recurrent headaches of the mother may be *crusta lactea* in her infant. The quiescent syphilis of the father is likely to develop an eruption in his offspring. So with other diseases which leave an indelible imprint on the constitution.

A recurrence of similar manifestations with attending peculiarities becomes of value as giving the tendency of the disease, its severity, and affording hints as to the remedy.

Exciting causes enable us at times to avoid critical turns in the future of the patient.

Among them we may mention teething, cold, emotional disturbances of the mother, nurse or patient.

*Case 1.*—Louis K. was a strong, healthy-appearing child, except that he had an eruption on his face, which did not harm the patient but was of great annoyance to the mother. She reported that her neighbors told her that the child was "decaying," and she must have it cured.

Under carefully selected remedies the eruption receded, but became much aggravated on the appearance of a tooth, and the mother was very much discouraged. The tooth appeared, and the eruption partially disappeared until another tooth created some irritation, when she was "wild" again. She consulted Prof. Ludlam, who gave her a little advice and sent her back to me, as she lived in my "parish." She was not satisfied and decided to try "*Cuticura*," as it had "cured" Mrs. ——'s baby in a short time. I did not hear of the little patient for a few days and supposed some better doctor had cured him. Some few days later I received a call to go at once to see him, and found him in a spasm.

The mother then told me of the marvelous effect of the salve in curing the rash. The eruption had almost disappeared. When I explained to her that if the child recovered the eruption would appear, she began to recall what had been said to her, but she had not heeded. As the child recovered from the more alarming developments the eruption did reappear. Subsequently an attack of indigestion, or a severe cold was enough to cause the disappearance of the eruption, and spasms resulted each time. The relation became so decided and the cause of so slight a character that the mother became alarmed at the slightest recession and dispatched a messenger even before there was time to develop the spasm. Suffice to say, that child is now four years old, had twenty-three spasms, and is clear, and to all appearance a healthy boy. After the teeth had all appeared the eruption receded and has not reappeared, but for some months he was subject to attacks of bronchial catarrh from slight exposure to wind or dampness.

*Case 2.*—Baby Mc. was a puny infant, and when a few weeks old developed an eruption on the head and face. This was the first baby in the family, and naturally a mother's pride was touched to see the little one disfigured. The wrestle with the different foods did not succeed in bringing the infant into a healthy condition. The closely selected remedy would not cause a vigorous response. An acute inflammation of the bowels set in later, and during the progress of the disease the eruption disappeared. The severer difficulty was controlled, and the skin trouble returned. After months the child got strong enough to be moved into the suburbs and fared better for a time.

Through inexperience the mother's judgment was at fault, and at an unguarded moment the child became chilled, the eruption disappeared, and in a few hours convulsions developed, and carried the frail little babe's life away.

While the majority of cases of *eczema capitis* may conform to the rule given by old authors, that the disease can not be cured until all the teeth appear we have seen exceptions, and a rule of that kind can not benefit the individual case.

Freedom from other pronounced manifestations of disease, the ability to avoid exciting causes, good nutrition, the probability of obtaining the necessary distinguishing symptoms, and the ability on the part of the prescriber to utilize

those symptoms, and find the curative remedy, should suggest the prognosis.

No two patients are alike in health, nor can they be alike when sick. The food of one may not be suitable for another when in health, and this is even more decided in the diseased organisms. We can not say that beefsteak is the only food suitable for an Englishman, and potatoes for an Irishman, although these representatives take this food. Neither should we say that *Arsenicum* is the remedy for eczema, because it is so frequently indicated in patients suffering from that disease. Individuality in the study of patient and remedy is the key to success in the treatment of disease.

In the treatment of skin diseases little things will often enable us to decide as to the proper remedy. The *Sulphur* patient is always worse from being washed. *Hepar sulph.* has decided aggravation from cold water and cold in any form. Under *Arsenicum* the itching is made much worse from exposure to the cold air. The *Rhus tox.* eruption is relieved by heat. This is a very valuable indication for *Rhus ven.* The *Mercurius* patient is worse from the same influence. The *Clematis* eruption is made worse by a moist application, cold or warm.

The *Apis* eruption is better when exposed to the cold air. Under *Rumex* there is decided aggravation from this exposure, even when undressing at night.

When *Mezereum* is needed the eruption is likely to be scaly, and thick scabs form; beneath them is pus which exudes on pressure; itching aggravates by warmth, and in many respects it is like *Mercurius*. The *Ant. tart.* eruption is pustular, and on healing leaves a bluish-red mark on the face or elsewhere.

*Cuprum* is frequently indicated for the convulsions, vomiting, and other alarming symptoms due to a reperussion of the eruption. *Caladium* is called for when the eruption disappears and asthma appears—alternation of the eruption on the chest and asthma.

*Calcarea carb*—the nettle-rash always disappears in the open air. Child scratches the head impatiently on waking.

*Sarsaparilla*—the rash appears as soon as he goes from the warm room into the open air.

*Ipecac*—the rash appears and itches. The scratching induces vomiting.

These hints are of value when the other symptoms are of a common kind, and hence are found under many remedies.

III. WINTER ITCH.—By T. S. HOYNE, M. D.—I wish to call the attention of the members of the society to a disease which has been pronounced winter itch. For a number of years I have noticed that as the cold waves of December come on quite a number of persons of all ages, complained of an itching of the skin, affecting, in the majority of cases, the outer aspect of the lower limbs, and usually the calves of the legs.

This itching, unless relieved by remedies, lasts until the warm days of April. Upon a close examination of the parts affected, nothing can be seen except the little bloody scabs, which have followed the excessive scratching. There is no perceptible elevation of the skin, no vesicles, as a rule nothing except what would naturally be seen after excessive irritation of the skin with the nails.

One gentleman informs me that when he wears boots instead of shoes he is not troubled with it, and he is satisfied, from careful observation, that the cold winds blowing against the legs unprotected by leather is the cause. However, I have found, on careful inquiry, that persons who wear thin cotton or linen underclothing, avoiding flannel, are not afflicted with this disease, although shoes are worn, thus showing that the irritation of these warm goods has something to do with the causation of this peculiar itch. Women seldom complain of it. It has been observed, also, that the disease is brought on or greatly aggravated by toasting the limbs before an open fire or a red hot stove. The man who sits over one of the street car stoves is almost sure to have an attack.

In view of the facts related, is it not probable then that the exposure to the extremes of heat and cold is the main exciting cause, producing a disease somewhat similar to eczema, but lacking the essential discharge?

It is seldom, so far as my experience goes, that the upper extremities or the trunk become affected, although I have seen two cases the past winter, in which the entire surface of the body was more or less implicated. These patients were students in the college class, and other causes were probably at work, such as change of air, water and diet, thus aggravating the disease, and protracting it in spite of a number of remedies which were prescribed.

The symptoms may briefly be given as follows: Intense itching of the skin on undressing at night, sometimes aggravated by the warmth of the bed, at others relieved after getting warm in bed; sitting before a hot fire aggravates. The itching is greatly increased in the open air on a very cold day, but, as a general rule, the itching is not troublesome though the day. It seems to bother the patient on arising in the morning. The itching is relieved by scratching, but leaves a burning sensation. In many cases the parts must be scratched until they bleed, before relief is obtained. A change in the weather from cold to warm relieves; whereas, a fall in the temperature aggravates. The patient is apt to have a return of the trouble the following winter.

In the many measures for relief, I have found hot salt water bathing often efficacious. Internally *Ledum*, *Rhus*, *Sulph.*, *Arsen.* have been given with more or less relief.

IV. FURUNCULAR INFLAMMATION OF THE EXTERNAL EAR.—By DR. F. H. FOSTER.—At the request of Dr. King for a short contribution on a subject relating to some skin affection of the eye or ear, I would call the attention of the society, for a brief space of time, to the following circumscribed or furuncular inflammation of the external ear. This disease is frequently met with, is very painful in its character, and is one to which the physician is often solicited to administer relief. It consists of an inflammation of the cutaneous and sub-cutaneous cellular tissue lining the auditory canal, which results in a boil or abscess, with a discharge of pus. This inflammation may be located in any portion of the canal, although the outer half, where the skin is thicker and richer in glandular tissue, is the

more frequent seat of the trouble. In the bony canal the skin is so thin and delicate and so closely connected with the periosteum as to practically form but one membrane. Inflammation in this section is rarer, though when it does occur its manifestations are much severer. This can readily be understood when we recollect how closely we are approaching the tympanic cavity, and that the outer layer of its membrane—the drum head—is formed by a continuation, inward, of the cutaneous lining of the canal.

An attack of circumscribed inflammation usually commences with a burning or itching in the outer portion of the canal, which sensation rapidly changes to pain. This pain is more or less severe, according to the depth of the abscess, and to its location, whether in the cartilagineous or bony section of the canal. Fever is generally present, and sometimes delirium. The auricle is sometimes swollen and tender, so that the patient cannot lie on the affected side. There is often pain, tenderness and swelling of the tissues in front of the ear, and over the articulation of the jaw; particularly is this the case if the disease is located on the anterior wall of the canal. On this account any movement of the jaws, as chewing, yawning, or even talking, is attended with an increase of pain. Less frequently is there any post-auricular infiltration of the tissues over the mastoid process. The cutaneous lining of the canal is swollen and excessively sensitive to the touch. The calibre of the canal is narrowed, and in some cases may be completely closed. The impairment of hearing varies from a slight dullness to an almost complete deafness. A simple mechanical obstruction of the canal does not produce as much hardness of hearing as where the tympanum has been invaded by an extension of the inflammation. As the swelling of the walls of the canal does not subside until there is a discharge of pus, the deafness is usually the last symptom to disappear. If, when the abscess breaks, a portion of the blood and pus runs down to the bottom of the canal, accumulates on the *membrana tympani*, and is not removed, the deafness persists. It is pretty safe, however, to promise the patient that there will be no permanent impairment. One attack of circumscribed inflammation

of the canal is generally followed by another. Indeed, so invariably is this the rule that they are spoken of as appearing in series or crops. Rarely is there more than one boil present at a time, but they follow from one ear into the other with so short an intermission that the sufferer has only begun to enjoy a short respite, when the itching and pain announces a fresh attack. Any attempt at examination of the ear with the ear funnel will be attended with pain. Notwithstanding, the ear should be carefully inspected, to determine the location and amount of inflammation, whether the canal contains wax or any foreign substance, and whether the drum-head exhibits any appearances of participating in the trouble. In the early stage of the disease, when the swelling is slight, this can easily be determined, but, later, if the tumefaction is great, nothing else can be seen.

The causes of this disease are often obscure. No class of mankind can claim exemption. The person who is surrounded with luxury, and indulges in the richest varieties of food, may suffer from an attack as quickly as the poor, the underfed or anæmic. A person whose system is in a perfect physiological condition is not very liable to an attack of furuncular inflammation.

It is rather generally accepted that mal-assimilation or some error in nutrition is at the root of the difficulty. Regarding the treatment of aural furuncles, most of the standard authorities advise an early and deep incision into the swelling, whether there is a prospect of finding pus or not, claiming that relief to the engorged tissues will be obtained by the bleeding, and that the boil will run its course in a shorter time. It seems to me, though, that very little is gained by this early incision, and that an unnecessary amount of suffering is caused. I am fully convinced that I have obtained as satisfactory and as speedy results when the early incision has been omitted; therefore it has been my practice not to cut into the furuncle until I am satisfied there is pus to be evacuated.

Poultices are ordinarily applied to a boil to hasten maturation, but they are not considered either good or safe practice



in an inflamed auditory canal. Hot water can be used *ad libitum* either by means of a syringe or douche, and during the intervals a hot water bag or hot bag of salt can be held to the ear. Heat is one of the most efficient modes of treatment we possess for quieting pain in the ear.

Equal parts of hot water and the fluid extract of *planto-go major*, dropped into the ear, sometimes do good service. The same can be said of warm glycerine applied on a small pledget of absorbent cotton. A few drops of Magendie's solution can be used in the same way. These applications are all for the relief of pain. The internal remedies to be thought of during the acute stage, are *Aconite*, *Belladonna*, *Hepar Sulphur*, *Mercurius* and *Pulsatilla*, and for breaking up the furuncular habit such remedies as *Arnica*, *Arsenic*, *Nitric acid*, *Sulphur* and *Silicea* are to be recommended.

Some years ago Dr. Loewenberg, of Paris, in writing on the cause of aural furuncles, claimed that they were due to a micrococcus, which was introduced from without into the system by means of the glandular ducts in the skin, and that the continuation or recurrence of the boils was owing to a fresh absorption of the pus containing these organisms. At the last meeting of the International Medical Congress, held in Washington, in 1887, the Doctor still maintained the same views on the subject. In mentioning his treatment I quote his own words. It consists in the application of an over-saturated solution of boracic acid in absolute alcohol. This compound he instilled into the meatus three or four times a day.

“As long as the boil is not yet opened a simple saturated alcoholic solution of the boracic acid is sufficient, but when pus is discharging, he preferred an over saturated solution, as it deposits a certain amount of boracic powder, dissolving gradually in the pus, and thus exercising a continual anti-bacterial action.”

The results which he claims are the following: An early application of the saturated solution of boracic acid in strong alcohol often arrests the boils; even in the cases where this abortive treatment should fail, the perseverent use of the over-

saturated solution always stops the otherwise nearly unavoidable succession of boils, originated by auto-contagion as I have called it. These results seem to me of great importance—firstly, because aural furuncles are known to be extremely painful; secondly, because, according to my experience, the longer the local furunculosis lasts the greater is the tendency of the boils to form in parts nearer and nearer the drum, and, consequently, to prove more and more painful.”

*Discussion.*—DR. J. D. CRAIG—I was very much interested in Dr. Gee’s paper, on account of the histories of suppressed eruptions. I recall a case of headache of five years’ standing, which I found<sup>^</sup> was preceded by an attack of diarrhœa. The diarrhœa has been preceded by dyspepsia, and the latter by an itching skin eruption. The eruption had been “cured” by an ointment. He was under my care nine months, and went back over the same course he had traveled before—from relief of the headache to diarrhœa, then dyspepsia and finally the itching eruption of the skin, of which he was finally and permanently cured.

DR. W. M. W. DAVISON—August 12, 1886, I attended a case of confinement, in every respect normal; when the child was four weeks old, I was again called and found its eyelids enormously swollen, very sensitive and bleeding if touched. I prescribed *Sulphur*. Improvement began on the third day and continued. An eruption came out on the face and spread all over the body, *Arum triph.* and other remedies prescribed did no good except *Kali. iod.*, which made some improvement. The type of the eruption changed often, and finally *Arum 3* and *30* seemed again to cure the case.

Contrary to my advice, Winslow’s soothing syrup was used to produce sleep, and the child finally died from cumulative action of the opium contained in it.

Dr. R. Ludlam held that while it is always a ticklish experiment to use local applications in skin affections, we may often relieve suffering and do no harm by selecting such of them as are mild and simple and not repellent in their action. This course could not interfere with the proper use of internal remedies.

Concerning Dr. Hoyne's paper, he could not help thinking that the reason of its prevalence as well as its symptomatology made it possible that what he calls "winter itch" might have arisen from eating what are falsely called "buckwheat cakes."

He would also enquire of Dr. Foster whether the occurrence of furuncles about the ear, as in boils and carbuncles elsewhere, had been accompanied by the presence of sugar in the urine.

DR. HOYNE defended his paper by saying that the similarity of the symptoms in the two forms of eruption had occurred to him, and therefore the question was asked of each patient, and he learned that buckwheat cakes had not been eaten by them.

DR. STURTEVANT—I have seen four cases of this winter itch, and I am glad to know what to call it. In neither case was it due to the use of buckwheat. I have not been very successful in their treatment. In one case relief was found from the use of Fowler's solution.

DR. SKILES—Winter itch has been prevalent in my district this winter.

DR. FOSTER—In reply to Dr. Ludlam, I am not aware that any particular attention has been given to the urine in these subjects of furuncular inflammation of the ear.

DR. HOYNE.—I remember one such case that I sent to Dr. Foster in which there was sugar in the urine from time to time.

DR. SKILES reported having used the fluid extract of *Sanguinaria* as a local application in the treatment of lupus, with much benefit to the patient.

Dr. M. A. Bowerman had brought a patient to the meeting, and having presented him, gave the following history of the case.

BILIARY CALCULI.—*Case.*—Frank N. is a German-American, aged thirty-five years. When first called to prescribe for this patient, I found the parotid glands very much

swollen and inflamed; the right ear was suppurating, and he could not sleep, it was so painful. It did not hurt him to swallow; the breath was offensive; the pupils were dilated; his temperature was 101 degrees. The complexion was deeply jaundiced, bronze-like in hue. He said that he ached all over, and thought that he had taken cold, as he had been exposed to cold and wet. The pain was aggravated by motion; the bowels were constipated. *Bell.* and *Bryonia*.

On the third day the ear became so painful that I gave *Aconite* and *Pulsatilla*, with local use of *Arnica* and olive oil, equal parts, dropped into the ear as hot as could be borne. On the fifth day the ear discharged, the throat was relieved, and the limbs did not ache. There was a deep-seated pain in the region of the stomach, and cramp whenever he tried to swallow anything. The constipation continues, with some tenderness over the abdomen; the face is flushed, intolerance of light, although the eyes were unusually clear and bright, the conjunctiva pearl-like in color; the tongue deep red and furred in patches.

The bronze tint of his complexion seemed to grow darker. The bowels moved on the seventh day, the faeces being hard, and dark colored. He is very sore and tender over the right hypochondrium; the urine is very dark and scanty, with a burning pain in the stomach, and desire to keep his knees drawn up.

Tenth day. — Temperature 104° in the evening, next morning at 10 A. M. it was 103½°. The abdomen is tympanitic, with gurgling. *Lycopodium* 12 gave relief. The stomach was intolerant to all solid food, a little mutton-broth, or strained oatmeal porridge being the only nourishment that could be retained. He was very melancholy and had been from the beginning of the attack. Indeed he had suffered from great mental anxiety and grief, with loss of employment, previous to his illness, and was constantly worrying lest his family would come to want. He was slowly growing weaker.

During the fifth week he had another physician in counsel who thought that he had typhoid fever, with some obscure complication; temperature 97°, complained of coldness over the abdomen; had a drawn, grey look, with an expression of suffering in his face; could not be moved, he was so sore. There was a hard swelling in the right hypochondrium, it could be felt distinctly, and was about the size of a man's hand. He had a light hemorrhage, bright red, mixed with pus, with every stool which was difficult of expulsion.

On the next day, which was the fortieth day, he had a very severe attack of colic, which began in the epigastric region and resulted in syncope. The family thought he was dying. They had administered spirits of *Camphor*. I placed the hands and feet in hot water, used hot application over the abdomen, and gave *Ammonia* by inhalation with a few drops in water internally as soon as he could swallow. I found that he had passed no urine for twenty-four hours; gave *Opium* 6 followed by *Carbo-veg.* 3, and in an hour's time he was warm and moist over the entire surface of the body. He had a profuse stool resembling wet wood-ashes, of a dark, bluish-grey color, with which were mixed numerous little bits, resembling kernels of corn. I gathered some of them for examination. He continued to have these attacks, although less severely, every three or four days, for about three weeks. The concretions became larger and more numerous, some of them as large as a small walnut, and finally passing two or three ounces of them every day. *Chelidonium* in the mother tincture would relieve the pain; but I think that *Lycopodium* relieved the constipation and the tenesmus. It has now been about three months since he had the first discharge of these concretions.

As he did seem to be able to partake of sufficient nourishment by way of the mouth, I procured a box of Fairchild's Peptogenized Milk Powder, had the milk prepared according to directions, and gave enemata once in three hours during the day. He began to improve, and in a week could drink an egg-nog made of the prepared milk two or three times a day and retain it. The tumor, or swelling over the right hypochondrium, has entirely disappeared, also the jaundice. I became satisfied that these concretions were gall-stones in their formative stage. The first of them passed were pure white, and of a calcareous substance of the consistency of putty, with a soapy, or greasy feeling; as they became more numerous they were softer, slightly yellow or creamy in color, with an occasional bit of what seemed like coarse yellow sand in them. They would harden when placed in alcohol. [Several bottles of these stones were passed for inspection of the members.]

Three weeks ago I changed the treatment, prescribing four tablespoonfuls of olive oil to be taken three times a day with peppermint, and also by inunction and enemata. He has had but one passage of the concretions since he began to take the oil, and that was on the third day, in the form of a fine crumbly mass. He has steadily improved, can walk three or four blocks, can eat almost anything, and is gaining flesh

rapidly. He is very sensitive to changes of temperature, especially to cold or damp; can not bear pressure over the abdomen, although very much improved from what it has been. The urine was examined several times, its specific gravity varying from 1016 to 1020, with no sugar and no albumen, but some mucus.

In proof of the diagnosis (Pepper, "System of Medicine," Vol. II, page 1058), *Biliary Concretions*:

"There are two classes of concretions which may occasion symptoms: inspissated bile, and regularly formed gall-stones. Slowly developing symptoms of jaundice from obstruction may arise from the deposit of particles of inspissated bile in the hepatic ducts, or sudden attacks of hepatic colic be due to the passage of concretions. When biliary calculi reach the intestines, certain kinds of disturbance may be caused by their presence there. Under the term biliary concretions must be considered, therefore, the mechanism of their production, their composition, the symptoms caused by their passage through the ducts (hepatic colic) and the *intestinal* disturbance due to their retention in the bowels.

"The biliary concretion which is properly a gall-stone has a definite form and a more or less well-defined crystalline structure.

"Calculi may be globular, ovoid, cylindrical and truncated cones. If a concretion forms in a duct or a single one is present in the gall-bladder, the shape is determined by the pressure of the walls of the duct or of the gall-bladder respectively. As found in the stools, and still somewhat soft, the shape will represent the form of the common duct through which it has been pressed. Such a soft, recently formed gall-stone will have the crystalline structure and chemical constitution of these bodies, and will therefore differ from apparently similar mass of inspissated bile.

"The number of calculi which may be present at any time, or be produced in the course of years, ranges from one to several thousand. One case is reported in which 7802 calculi were found in one gall-bladder; but they must have been minute in size. Two hundred and thirty were obtained from one gall-bladder which they entirely filled they have an average weight of two grains each. Another collection of calculi removed from a closed gall-bladder contained forty-five of large size, distending the organ and forming, which projected beyond the margin of the liver. Hepatic calculi are rarely solitary; hence, if one attack of hepatic colic occur, others may be expected. In color, gall-stones vary from a clear white to a dark brown, almost black tint. The most usual

tint of the mature calculi in the gall-bladder is that of the ripe chestnut. If composed of pure cholesterine the color will be whitish, opaque or glistening, and almost translucent. Among the causes of biliary calculi are malarial influences, the use of pork as a diet, great mental anxiety, excessive heat."

I find the following on good authority ("Quain's Dictionary of Medicine," page 525):

"The chief chemical constituents of human gall-stones is cholesterine; some gall-stones are wholly composed of this substance; most contain 70 or 80 per cent. Pathology.—What is the cause of the first formation of a gall-stone? It is not simply concentration of the bile, since the cholesterine and pigment remain in solution so long as the bile is unchanged; but the beginning of decomposition of the bile acids causes a precipitation. The cholesterine is likewise thrown down when the reaction of the bile changes from alkaline to acid. The diagnosis of gall-stones is often more or less difficult. Some physicians think that the diagnosis should not be made unless the concretions be found in the stools. Cancer of the head of the pancreas may readily be mistaken for gall-stones in the common duct."

Again (Arndt's "System of Medicine" Vol. I, page 871):

Chlorosis and the cancerous dyscrasia may spread a light-yellow tint over the skin, but they leave the conjunctiva intact. And beyond these two there is nothing which even a lively imagination can suggest as offering a possibility of mistake. When, however, jaundice is recognized, the work of diagnosis is not necessarily at an end. The question is: Is this symptom *the* symptom and *the* disease, or is it a *symptom* of some other disorder, and nothing but a symptom. If it be the result of the impediment offered by a gall-stone or the pathological condition obtained in acute yellow atrophy, it is not the disease but a symptom. It would be out of place to here detail the diagnosis of these and other hepatic disorders. Whether the trouble be less than or altogether different from jaundice is germane to the present purpose and is easily decided. Whether it is more than jaundice involves the whole subject of hepatic diseases; for it must cover pathological conditions differing, of whose precise existence we cannot be exactly informed, and about which we can do but little more than group plausible theories."

This patient has been under treatment for seven months; during that time the following remedies were used when indicated. *Ars. alb.*, *Bapt.*, *Bell.*, *Bry.*, *Cham.*, *Carbc.*

veg., *Chel.*, *Chin. sulph.*, *Lyc.*, *Merc. corr.*, *Nux. vom.*, *Opi.*, *Puls.*, *Rhus. tox.*, *Tereb.*, *Arnica* and *Olive oil*. I think *Lyc.*, *Chel.*, and *Olive oil* have been most beneficial. His disease was pronounced malignant, and therefore incurable by three of our most eminent physicians.

This report was discussed, and the patient examined by several of the members present.

TUBERCULAR PERITONITIS AND THE ABDOMINAL SECTION.—Dr. R. Ludlam called the attention of the society to the final history of a case which he had reported at its last meeting.\* The case was one in which he had made a section of the peritoneum for a final diagnosis, and had found the tubercular deposit studing the upper surface of the uterus and broad ligaments and the pelvic peritoneum generally, as well as the mesentery. The patient had recovered from the operation, but the abdomen had refilled with the ascitic fluid so that each month afterward it had been necessary to remove it by aspiration. This tapping was repeated four times, when she sank away and died from inanition and exhaustion. A careful autopsy was made by Drs. R. Ludlam, Jr., R. C. Bain and J. H. S. Johnson.

The specimens obtained, and which are herewith presented, illustrate a very important result from the section of the peritoneum, for, as you will observe, the surfaces which at the time of the operation were thickly covered with the miliary, or *grains de riz* tubercules, are perfectly smooth and normal. Nothing of the deposit is to be found upon the peritoneal surface. The ovaries are studded with larger masses, which are evidently tuberculous, and so likewise is the mesentery. While, however, the fine tubercules that were so perceptible when the abdomen was opened have disappeared from the free surface of the peritoneum, the left kidney, as you will observe, is full of them. The reason for this fact is explained by the position of the kidney outside of the peritoneal cavity, where it could not be influenced by the abdominal section—all of which supports the idea that, while the exploratory incision may cure a strictly peritoneal tuberculosis, it will not affect the development of the disease in other abdominal organs.

\*The *Clinique* for February 15, 1888, page 58.



The stomach, which was very much distended at the time the section was made, and which was indurated at its pyloric extremity, has been preserved. You will note that, although the patient ate and drank very little for some weeks before her death, this organ is unusually large, and that its pyloric extremity is the seat of a deposit which has all the physical characters of tubercular infiltration.

AN INTRA-LIGAMENTOUS CYST OF THE OVARY.—Dr. R. Ludlam showed a cyst which he had removed from the right, broad ligament, and made some remarks upon the formation of these peculiar growths. In this case, the patient being twenty-six years old, the trouble began nine years ago, at which time, while helping to move a piano, she “felt something give way” in her right side, and almost fainted from the pain. She kept around for a week, with lying down part of the time, when the pain became so intense that a physician was called. He examined her and found a hernia, reduced it, and applied a bandage, which she wore for several months. She has never been well since, having had an almost constant pain either in the right or the left side, but chiefly in the latter. After any little unusual exertion she became very tired, and had the sensation as if her abdomen would burst. This symptom was frequent after eating. She suffered with inveterate constipation, and the urinary symptoms were very painful and annoying. There was always pain before and after urinating, and a constant urging. The menstrual flow has been very irregular, rather scanty, coming sometimes every two weeks, although not particularly painful. She has been treated for everything imaginable, in all sorts of ways. Has had local treatment with tampons and suppositories, and wore plasters of every description. Has been troubled a great deal with insomnia, which became worse during the last year.

The operation was made this morning, and despite the very extensive adhesions which had fused the growth with the intestines and the sessile base of the tumor, was finished satisfactorily. The tumor weighed two pounds. The stump included the whole length of the right broad ligament, in which the lower segment of the cyst was encapsulated.

[March 15.—This patient is now at the close of the second week, and will be up in a day or two.]

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*THE ALUMNI ASSOCIATION MEETING.*

The fifth annual meeting of the Alumni Association of Hahnemann Medical College and Hospital was held at the Hotel Richelieu, Wednesday evening, February 15, 1888. The meeting was an unusually large and interesting one. The president's address was delivered by Dr. C. N. Dinsmore, of Omaha. This was followed by short speeches by Drs. M. H. Parmelee, of Toledo; Dr. W. A. Shepard, of Elgin; Dr. Missick, of Illinois, Drs. Shears, W. A. Barker, E. M. P. Ludlam, J. P. Cobb, N. C. Kemp, W. H. McCracken, and others. There were also many members of the graduating class in attendance, and were represented by speeches from Drs. Brant, Dick and Leonard. Drs. R. Ludlam and Arnulphy favored the association with their presence, and helped to make the evening a very pleasant one. Many stories were crowded into the "five minute" speeches, and the recent graduate learned for the first time that the fun was not alone in his college days.

There was an earnest desire on the part of all present to inaugurate a movement to raise an alumni fund for the college hospital. To put this matter in shape a committee of three was appointed by the chairman. This committee was composed of Drs. M. H. Parmelee, L. A. Bishop and G. F. Shears. As soon as their plans are formulated a printed report will be mailed to every alumnus. Dr. C. N. Dinsmore very kindly offered to head this movement with a subscription of \$1,000, to be paid as soon as their plans were matured. Several members of the different classes willingly offered to start the movement in their respective classes. Very much interest was manifested in this project, and, as it comes within the financial reach of all, it is hoped that every alumnus will help the ball as it rolls.

The officers for the following year were elected as follows: President, Dr. M. H. Parmelee, of Toledo, Ohio; first vice-president, Dr. W. M. Davidson, Chicago; second vice-president, Dr. J. H. Thompson, Pittsburgh, Penn.; secretary, Dr. H. V. Halbert, and Dr. J. P. Cobb, as treasurer; necrologist, Dr. Mary H. Landreth. The executive committee consists of Drs. G. F. Shears, C. L. Missick and N. C. Kemp.

## Commencement Exercises

OF THE HAHNEMANN MEDICAL COLLEGE AND  
HOSPITAL—SESSION 1887-88.

The Twenty-eighth Annual Commencement Exercises of this institution were held in the Grand Opera House, Chicago, at 2 P. M., on February 16, 1888. As usual the building was filled to overflowing with a friendly, fashionable and enthusiastic audience. The programme opened with prayer by Rev. Dr. F. W. Gunsaulus, of the Plymouth Congregational Church. The music was furnished by a full and popular orchestra. Then came

### THE ANNUAL REPORT,

BY PROF. E. S. BAILEY, M. D., REGISTRAR.

*Mr. President:*—The exercises of to-day will close the twenty-eighth year in the history of the Hahnemann Medical College and Hospital of Chicago. It is a pleasure to state that the college is in a prosperous condition. The attendance has been large, the friends of the institution are numerous, and they are always ready with counsel and encouragement. In the faculty and teaching corps there is perfect harmony, and all have been determined to do their best to further the common interests of the students, the profession at large, and to do their full duty to the State. It is but right to say, also, that the faculty of this college have cheerfully worked to comply to the letter with all the recommendations and requirements of the Illinois State Board of Health, and that in their effort to improve the standard of medical education, to perfect the scholarship of the student, and to give each and all both a scientific and clinical training no effort or labor has been spared. During the winter session now passed more than 800 lectures have been delivered, of which 160 have been either surgical or medical

WAS TO VILL

DOOR JACOB

clinical lectures, the balance didactic; and, in addition to this, instruction in sub-clinics has been given to the senior class, representing 125 lecture hours, making nearly 1,000 lecture hours that have been filled by the instructors in the several departments.

Too much can not be said in praise of the class of students now before you, awaiting your bestowal of the diploma of the college. Without exception this class has been diligent and attentive, and each student has worked with zeal and enthusiasm. With patience and perseverance they have given cordial support to all the requests and regulations of the trustees and of the faculty. In recommending them to you, sir, we remember with much pleasure the uniform courtesy and kindness which has been accorded us, and in this, the last word of the term, we can but turn and again wish the members of '88 that their success shall be measured by the true standard of a well ordered and a well spent professional life. The lecture course has been attended by quite 200 students and practitioners of medicine. Far away Maine has sent several students, and the same is true of California and Washington Territory. One comes direct to us from South Australia. The Eastern and Middle States continue to send us a large quota, New York is represented by fifteen students, nine being in the graduating class. Rhode Island spares us but a single student, and Delaware sends us four. The Western States are largely represented, and we have been pleased to note the spreading of our system of medicine by the additional number of students coming from the South. In the summary of the literary qualifications now necessary to enter this college we note that thirty-nine have filed certificates of graduation or attendance upon high or preparatory schools; thirty-one from seminaries, normal schools or academies; twenty-five have received a college drill; forty-two have presented teachers' certificates; four have taken degrees in the European universities; others have met the requirements of the entrance examination.

The clinical and hospital drill, I am happy to say, has been of unusual interest, both as regards numbers and variety

of cases shown. This growing feature of medical education has been most highly appreciated by the entire class of students.

Seventy-eight students have been examined in all the branches taught in this college, and they have complied with all the requirements of the board of health, as well as of this institution, and, upon the full vote of the faculty, are herewith presented as fit for the degree which is in your power to bestow.

*ADDRESS OF THE PRESIDENT ON CONFERRING  
THE DEGREE.*

BY DAVID SHEPARD SMITH, M. D.

When the members of the graduating class had been summoned, and were in position upon the stage, the impressive ceremony of conferring the degree of Doctor in Medicine and Surgery was performed in the most agreeable and acceptable manner by the president of the college, Dr. David S. Smith. This was followed by a few earnest and eloquent remarks concerning the importance of their newly acquired function, the dignity of the position assumed, and the responsibility of each and all to the profession and to the public in the performance of their professional duties.

LIST OF GRADUATES.

ADAMS, GEORGE FRANCIS,	New York.
ALEXANDER, GEORGE LEVI,	Wisconsin.
ARNOLD, ROMUS,	Illinois.
AURINGER, ALBERT E.,	Wisconsin.
BAKER, FRANK W.,	Indiana.
BALLINGER, JOHN P.,	New Jersey.
BEEKMAN, JESSE H.,	New Jersey.
BITTINGER, FRANK D.,	Minnesota.
BLACKNEY, SAMUEL,	South Australia.
BLACKWOOD, ALEXANDER LESLIE,	Illinois.
BRANT, HEZEKIAH W.,	Illinois.
BROWER, WILLIS A.,	New York.

CAROLUS, WILLIAM B., . . . . .	Illinois.
CHAPMAN, E. ELDRED KELLOGUE, . . . . .	Michigan.
CHISLETT, HOWARD ROY, . . . . .	Minnesota.
COLLIER, AMY WILCE, . . . . .	Illinois.
CRAMER, WILLIAM E., . . . . .	Illinois.
DENNIS, MARY A., . . . . .	Illinois.
DICK, EDGAR G., . . . . .	Kansas.
DRESSER, E. DELL, . . . . .	New York.
EBERSOLE, JOSEPH R., . . . . .	Illinois.
GOODING, ANNIS S. H., . . . . .	Michigan.
GRAHAM, JOHN JAMES, . . . . .	Indiana.
GRAVES, FRED EVERETT, . . . . .	New York.
GRIGGS, ELMA, . . . . .	Pennsylvania.
GROB, ARTHUR R. F., . . . . .	Wisconsin.
HACKER, WILLIAM HENRI, . . . . .	New York.
HARDY, ANNA C., . . . . .	Illinois.
HENNESSY, MARGARET E., . . . . .	New York.
HILL, ORIMAL F., . . . . .	Iowa.
HOLLAND JOSEPH H., . . . . .	Missouri.
HOWE, MELVIN F., . . . . .	Iowa.
JORDAN J. EUGENE, . . . . .	Illinois.
KEELER, CHARLES BRADLEY, . . . . .	Connecticut.
KENDALL, SARAH A., . . . . .	Massachusetts.
KRUDOP, D. TONJES, . . . . .	Minnesota.
KRUDOP, MARTINE MUEHLIG, . . . . .	Minnesota.
LANNING, WILLET SCOTT, . . . . .	Iowa.
LEONARD, EDWARD JOSEPH, . . . . .	Illinois.
LYON, HOWARD N., . . . . .	Michigan.
OLSEN, VALDEMAR, . . . . .	Kansas.
PATTERSON, HENRY S., . . . . .	Iowa.
PEARSON, ALFRED W., . . . . .	Iowa.
PURSEL, JAMES PERRY, . . . . .	Pennsylvania.
PIKE RHODA, . . . . .	Maine.
PLACE, JOSEPH JEREMIAH, . . . . .	Rhode Island.
PULFORD, CHARLES H., . . . . .	Connecticut.
RHODES, ROBERT RAIKES, . . . . .	Indiana.
RUSSELL, GEORGE ABELL, . . . . .	Wisconsin.
SCOTT, FREEMAN J., . . . . .	Illinois.

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SHEPARD, WILLIAM T., . . . . .	Illinois.
SHUTTERLY, EUGENE E., . . . . .	Illinois.
SIEGFRIED, J. P., . . . . .	Ohio.
SLAUGHTER, LOUIS N., . . . . .	Delaware.
SMITH, GEORGE RUFUS, . . . . .	Vermont.
STEELE, CHARLES H., . . . . .	Wisconsin.
STEWART, ESTELLE, . . . . .	Kansas.
STEWART, WILLIS B., . . . . .	Indiana.
STILES, VERNON W., . . . . .	Illinois.
TAYLOR, M. BEATRICE, . . . . .	New York.
TEDMAN, LUCIUS J., . . . . .	Michigan.
THACKER, WILLIAM HENRY, . . . . .	New York.
THOMPSON, A. H., . . . . .	Ohio.
THOMPSON, EDWARD KENNEY, . . . . .	Michigan.
TURBETT, SAMUEL O., . . . . .	Michigan.
TUTTLE, EDWIN RUSSELL, . . . . .	Wisconsin.
VAN DOREN, HENRY W., . . . . .	Nebraska.
VON HORN, MARY LOUISA, . . . . .	Illinois.
VARY, WILLIAM HAROLD, . . . . .	Illinois.
WARD, DAVID W., . . . . .	Illinois.
WATERS, FRANK RICHARDSON, . . . . .	Illinois.
WEEKS, GEORGE H. P., . . . . .	Illinois.
WOODBURN, WILLIAM, . . . . .	Kansas.
WHITTIER, GEORGE N., . . . . .	Illinois.
YARNELL, JAMES E., . . . . .	Ohio.
YATES, CLINTON J., . . . . .	Nebraska.
YOUNG, DANIEL F., . . . . .	New York.
YOUNG, JULIUS, . . . . .	Illinois.

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### VALEDICTORY ADDRESS.

BY REV. F. W. GUNSAULUS, D.D.

Departing from the usual custom, the valedictory address consisted of a poem entitled "Paul and Luke." The matter of this production, as well as the manner of its delivery, were altogether so excellent, enjoyable and appropriate that we very much regret our inability to obtain a copy for publica-

tion herewith. No one who heard it can doubt that the art of putting practical ideas into rhyme is still preserved; or that homely and yet wholesome advice may be given or sung in a melodious form.

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### THE PRESENTATION OF PRIZES.

After the valedictory came the presentation of prizes, in which the new doctors and their numerous friends were very much interested. This part of the performance was conducted by Prof. Hall, in his usual felicitous manner, each member of the faculty bestowing his own prize upon the lucky recipient amid the applause of the delighted audience.

The Dr. D. S. Smith prize of \$50, offered for the best general examination to H. R. Chislett, of Minnesota.

The Halsey Bros. annual prize of a buggy case, offered for the second best examination to E. Dell Dresser, of New York.

Prof. Hall's prize for the best final examination in surgery to A. L. Blackwood, of Illinois.

Prof. Hawkes' prize for the most accurate prescriber in the medical clinic.

Prof. Leavitt for the best final examination in obstetrics to Sarah Kendall, of Maine.

Prof. Bailey for report on the didactic lectures on the diseases of women to Mrs. Anna C. Hardy, of Illinois.

Prof. Fellows on some subject to be announced during the term to Eugene Yarnell, of Ohio.

Prof. Gilman, \$20 for the best final examination in sanitary science to H. N. Lyon, of Michigan.

Prof. Vilas, for the best final examination on the eye and ear to H. R. Chislett, of Minnesota.

Prof. Laning awarded a prize for the best thesis on bilious colic to H. N. Lyon, of Michigan.

Prof. Shears, for best report of his clinical orthopædic lectures to E. E. Shutterley, of Illinois.



Prof. King, for best examination in medical chemistry to C. F. Menninger, of Minnesota.

Appointment of House Physician, to V. W. Stiles, of Illinois.

Appointment of House Surgeon, to H. R. Chislett, of Minnesota.

### THE RECEPTION AND BANQUET.

The reception and the banquet, which close the season, were held in the Hotel Richelieu, beginning at the sensible hour of 6.30 P. M. The company, the visitors, the beautiful halls and decorations, were all the more enjoyable and attractive, because the Alumni Association played the part of host; and it goes without saying that this was the most enjoyable of all the occasions of a similar kind that have been held, either in Chicago or elsewhere. The menu was suited to the most fastidious taste and palate; the food, the flowers, the service and the music were most excellent, beautiful, *comme il faut* and delightful. The toasts were offered in his inimitable way by Prof. Vilas, and were responded to by Profs. Smith, Hoyne, Hall and Ludlam, and by Drs. Dinsmore, of Omaha; Parmelee, of Toledo, of the Alumni Society, and Dr. George F. Adams, of New York, from the graduating class. The Class songs were interspersed very much to the delight of the party, and we are tempted to insert one of them as a specimen, with which to close our report of this very interesting anniversary.

#### THE PROFESSORS OF '88.

Tune—*Vive la compagnie.*

A is for Arnulphy who gives you a pat,  
 Vive la compagnie!  
 On the side of the chest and says, vat you call dat?  
 Vive la compagnie.

Chorus.—Vive l'amour, vive l'amour,  
 Vive la, vive la, vive l'amour.  
 Vive la, vive la, vive l'amour.  
 Vive la compagnie!

B is for Bailey who takes down your name,  
                                   Vive la compagnie!  
 Though modest, he surely gets there, just the same,  
                                   Vive la compagnie!—Chorus.

F is for Fellows who fills the first chair,  
                                   Vive la compagnie!  
 For religion and regulars he doesn't care.  
                                   Vive la compagnie!—Chorus.

G is for Gilman and also for Gee,  
                                   Vive la compagnie!  
 With the micrococci and their high potency,  
                                   Vive la compagnie!—Chorus.

H is for Halbert, Hawkes, Harvey and Hall,  
                                   Vive la compagnie!  
 The last one of course is the king bee of all,  
                                   Vive la compagnie!—Chorus.

K is for comtoal, chemical King,  
                                   Vive la compagnie!  
 Who says all the hard ones to my clinic bring,  
                                   Vive la compagnie!—Chorus.

Leavitt, Ludlam and Laning begin with an L,  
                                   Vive la compagnie!  
 Who their lecturers enhance by the stories they tell.  
                                   Vive la compagnie!—Chorus.

R is for Reed who is one of the ilk,  
                                   Vive la compagnie!  
 He says the best food for a baby is milk,  
                                   Vive la compagnie!—Chorus.

S is for Shears, who on tumors descants,  
                                   Vive la compagnie!  
 He mends crooked legs when he gets a good chance.  
                                   Vive la compagnie!—Chorus.

V is for Vilas, a prominent vowel (I),  
                                   Vive la compagnie!  
 Who lectures on eyes with the aid of a towel,  
                                   Vive la compagnie!—Chorus.

Watry winds up the list with a capital W,  
                                   Vive la compagnie!  
 He fits glasses for Vilas—his quizzes will trouble you,  
                                   Vive la compagnie!—Chorus.

Now we'll sing just one more for the Hahnemann College,  
                                   Vive la compagnie!  
 It ranks first in the land for acquirement of knowledge,  
                                   Vive la compagnie!—Chorus.

E. G. D.

## Miscellaneous Items.

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The Hospital Notes and Reviews are crowded out of this issue.—Prof Laning will furnish another lecture on Lithæmia for the next number.—The post-graduate course closes the last of this month. Seventy-eight practitioners and students have been in attendance; among this number are several old school graduates, and representatives from the Eclectic College. The course has given entire satisfaction to all.—Prof. Ludlam has gone to Southern California to perform a hysterectomy.—The faculty are not conducting a training school for nurses. The numerous applications for information suggest that such an impression is abroad.—Dr. Charles R. Mayer has removed from St. Martinsville to New Orleans, La.—Dr. W. B. Carolus has located at Sterling, Ill.; Dr. J. R. Ebersole at Monmouth, Ill.; Dr. Joseph I. Place at Providence, R. I.; and Dr. J. P. Pursell at Williamsport, Penn.—Drs. Sarah Kendall and Rhoda Pike have been appointed as internes in the Homœopathic Hospital at Philadelphia.—Dr. Alice Ewing will locate on Oakwood Boulevard, near Cottage Grove Avenue, Chicago.—Dr. W. E. Reed has changed his residence to 427 La Salle Avenue.—The Hahnemann Medical Association of Iowa will hold its annual meeting at Iowa City, May 22, 23, 24.—Dr. O. F. Hill has located at Epworth, Iowa; Dr. G. F. Adams at Pulaski, N. Y.; Dr. F. J. Scott at Rock Falls, Ill.—Dr. T. S. Huffaker, of this city, and Miss Myra J. Rowell, of Pennebroke, N. H., were recently married. Dr. W. B. Carolus is reported married on March 7.—W. D. Chaffee, M. D., of Three Rivers, Mich., is doing a flourishing business.

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# THE CLINIQUE.

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## Original Lectures.

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### *THERAPEUTICS OF LITHÆMIA.—BRYONIA.*

A LECTURE DELIVERED IN THE COURSE ON THE PRACTICE OF MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, BY C. E. LANING, M. D., PROFESSOR, ETC.

Almost every one knows that Bryonia is good for "liver complaint," therefore you are, no doubt, prepared to see it marshalled among the combatants of lithæmia. While, in the present state of medical knowledge, it is impossible to say always just where a remedy makes itself first felt in the organism, still, by careful observation, reinforced by an adequate knowledge of the anatomy and physiology of the economy, much valuable insight into this very important matter may be obtained.

Although there may be exceptions to the following statement, I think it will be found to be true in a majority of cases: When a remedy develops, in the course of its proving, well defined mental symptoms, it may be taken as almost proof positive, that said remedy acts largely, if not exclusively, upon the great sympathetics. A remedy must not only act upon the same tissues which are affected by the disease which it is given to cure, but must also act in a very similar manner, making its impression upon the same point of the organism that the disease originally did. This being true, a careful study of the etiological factors of diseases assumes a very important role, for in this way we are often enabled to learn what parts

of the economy are first affected. If, therefore, certain diseased conditions are known to arise as the result of psychical influences upon the brain, remedies which produce similar symptoms or which cause the disease just referred to must, by analogy, act primarily upon the brain, the resultant symptoms being caused by the disturbance of the cerebral cells being conveyed to other parts by means of the sympathetic nervous system.

How many times has every physician of experience seen morbid conditions of the various parts of the organism arise as a result of some powerful impression made upon the brain, and how many times has he cured it with aconite, chamomilla, bryonia, opium, hyoscyamus, pulsatilla, gelsemium, ignatia, etc., etc. ?

Any one who knows how to interpret symptoms, not only as regards the remedy to which they may correspond, or as regards their significance in a diagnostic way, but also knows how to reason out the centres from which they originated and the paths by which they came, will see that all, or very nearly all, the symptoms removed by the above remedies were caused through an affection of the sympathetic. Hence, if a liver or stomach or kidney may be deranged functionally, and even, as is claimed by some, may become affected by malignant organic disease, through the influence of the mind, does it not stand to reason that the remedies removing these conditions must act specifically and primarily upon the same cerebral centres, which have been affected in the first place by purely psychical influences? Our old-school friends laugh at the idea of letting the fact that a diseased condition is due to fright or any other emotion influence us in the selection of a remedy. If an emotion may be looked upon as an etiological factor, and that it may be there can be no manner of doubt, as is amply proven by the statements of their own standard authors, then why not take it into consideration in the selection of a remedy just as much as if the disease for which we are prescribing was due to sudden and great chill or overpowering heat? One group or class of etiological factors can not be used as a basis or guide for therapeutic measures

while another group is ignored, at least not if therapeutics ever attain to the dignity of a science.

This may seem to you a considerable of a preamble to the study of Bryonia in lithæmia, and possibly as irrelevant to the subject, but I desire as much as possible, in the short time allotted me for the purpose, to make you familiar with certain facts pertaining to the selection of the remedies I shall lecture upon, but also having a bearing upon therapeutics in general. Under the mental symptoms of Bryonia we shall not only observe those which will correspond to the mental symptoms which are characteristic of lithæmia, but shall also see that they indicate an affection of the sympathetic. You will observe that some of the mental symptoms at once establish a relationship between Bryonia and Chamomilla, while they at the same time serve to distinguish Bryonia from Calcaria.

The following are the lithæmic mental symptoms of Bryonia: "Great depression and morose mood without cause." It is not really correct to say that any symptoms or morbid expressions are without cause, but I give the symptoms just as they appear in the materia medica. "Irritable mood, wishes to be let alone. (Antimony Crud., Nux Vom.) Very irritable, obstinate and passionate." These symptoms need no further explanation at present, but I wish to call your attention to another symptom which is found in the mental group: "Inclined to fright, fear and vexation, bad effects from violence and anger."

This last symptom shows conclusively that through the cerebral emotional centres, through the sympathetic, the Bryonia patient is very liable to become affected. This tendency of the sympathetic to become involved under Bryonia is not alone shown by this symptom, but also by the fact that the gastric and hepatic derangements to which Bryonia is curative, are almost always aggravated if not produced by exposure to heat. Through the sympathetic system the ill effects (as well as the beneficial) of heat or cold are made manifest.

You have become so familiar, through repetition, with the

head symptoms of lithæmia, that I scarcely need draw your attention to the parallel between them and many of the cranial or cerebral symptoms of Bryonia. That this remedy affects particularly the nerve centres which control fibrous and serous tissues there can be no doubt. I say the nerve centres, for, as you know, I do not believe that remedies ever—or if at all, very seldom—act directly upon a tissue, except it be nervous. Many of the head symptoms of Bryonia point conclusively to involvement of the fibrous tissue entering into the formation of the *dura mater*. It is well known that the cerebral mass itself is little susceptible to pain from congestion or any of the sources of ordinary pathological irritation. The *dura mater*, however, is supplied by the fifth nerve, the most exquisitely sensitive one in the entire body. The fibrous tissue entering into the formation of the eye and its appendages are also acted upon by Bryonia. We are therefore prepared for such symptoms as these: "Pressing outward in the frontal region and left eye-ball, especially on stooping. Headache from slight motion, as moving the eyelids;" "great heaviness of the head and pressure of the brain forward."

If we analyze these symptoms, we at once see the part the *dura mater* plays in their production. Bryonia acts primarily upon the sympathetic fibres which pass to the *dura mater*, or, at least, those controlling the arterioles of that membrane. It throws the vaso-motor filaments to those vessels into a state of paresis, and hence the quantity of blood is increased in the involved territory. Fibro-serous membranes tolerate but poorly congestion or inflammation, for the reason that they are so firm and unyielding. Having such a condition set up in fibrous portions of the *dura* and eye, motion and gravitation produce a decided and unpleasant effect. The pressure upon the sensory nerve filaments of the *dura* give rise to a sensation as if the brain was falling forward, or was about to press out of the forehead. Of course, we know the brain does not really move forward, but when stooping or leaning forward the amount of blood is increased in the meningeal vessels, pressure is exerted upon the sensory nerves of the *dura*, and hence the sensation.

There are other symptoms of lithæmia and bryonia which point to an affection of the vaso-motors of the cerebral vessels. If rightly interpreted, these latter symptoms, which I will soon mention, indicate which vessels are affected. The symptoms referred to are the following: "Confusion of the head, especially of the forehead; head confused and aching, as after a night's dissipation; does not wish to rise in the morning on awakening."

While the first group of symptoms given are caused largely by over-distension of the meningeal arterioles, the last group is due to an entirely different system of vessels, viz.: the cerebral cortical capillaries, which, in the anterior portion of the brain, belong to the system of blood vessels having their ultimate origin from the internal carotids.

That the vaso-motors controlling the cerebral circulation are affected in the manner already intimated, receives additional proof from this symptom—"rush of blood to the head."

This symptom is to be distinguished from a similar one under Belladonna. In this last remedy the cerebral vessels are seldom, if ever, involved without a simultaneous affection of the capillaries of the integument of the face, and often of the neck. Pardon me if I make a slight digression, in order to call your attention more particularly to this difference between the two remedies just mentioned. Bryonia seldom produces dilatation of the peripheral capillaries of the integument; it is those of the deeper structures which are most frequently involved. Thus, in a Bryonia case of cerebral congestion or meningitis, the face is not only not flushed, but is often even pale. This condition you will rarely or never find occurring under Belladonna—the face will almost always be found to be red and hot if there is cerebral or meningeal congestion or inflammation calling for Belladonna. One more illustration, and I think this fact will be sufficiently impressed upon your minds: In certain puerperal cases the mammæ become congested and tend strongly toward inflammation. In such a case, if Belladonna were indicated, there would be heat, redness and throbbing in the breasts. When Bryonia



is called for, however, a different condition will be noted, although the congestion of the deeper tissues may be just as great and inimical as it was under Belladonna. This is clearly proven by the following characteristic of Bryonia: "Tensive, burning and tearing pain in the mammæ—they are pale, but hard and painful."

This peculiarity as regards the physiological action of Bryonia, if remembered, may serve to assist you, sometimes, in its selection, and at the same time prevent you from being deceived in regard to the degree of congestion or inflammation of some organ, because there is not a corresponding evidence of surface heat or redness.

The other cerebral symptoms under Bryonia, which give evidence of a lithæmic origin, are so similar in character to the ones already mentioned that it is scarcely worth your time for me to repeat them. One peculiarity in the headache of Bryonia it may be worth while to call your attention to, as it will fasten more firmly what I have already told you. Almost always, if a patient suffering from a Bryonia headache coughs, it causes a decided aggravation of the pain. Remembering that the site of the lesion which gives rise to the pain in a Bryonia headache is in the meninges, principally the dura, and recalling the fact of its firm, fibrous structure, you at once see that any sudden increase in the amount of blood in that tissue must cause an increase of pain. During the act of coughing the thorax is temporarily contracted, its superior opening is diminished, and hence the return of the blood from the brain and meninges, which takes place through the internal jugular, is retarded, while the blood passing to these structures, through the carotids, receives a sudden onward impulse, the two conditions of necessity result in a temporary sudden increase of the amount of blood in the cavity of the cranium, making itself manifest at such points as are already diseased and sensitive.

We will now proceed to the study of a group of symptoms which you will at once recognize as a portion of those so often named in summing up the symptom complex which we term lithæmia. You will notice also that these same symptoms are

all more or less characteristic of Bryonia. Constipation is a very usual symptom of lithæmia; fullness of the stomach and intestines or in the region of the liver, with pain varying in character in one or all of these locations, you are aware are symptoms which are almost pathognomic of lithæmia, at least, are very seldom missing in a well-defined case. Under Bryonia we find all of those. The constipation is characteristic of the remedy, though not necessarily of the disease. Let us see what this peculiar form of constipation signifies.

The passages are "very dry, large and hard, evacuated only after much straining; hard black and dry stool as if burnt."

Here we observe every evidence of an affection of the sympathetic. The great splanchnic originating from the 5th, 6th, 7th, 8th and 9th dorsal ganglions of the great sympathetic, contain the fibres which not entirely, but very largely, inhibit the peristalsis of the intestines. A peculiar and characteristic feature of the Bryonia stool is that it is almost invariably large in size. The intestine being a hollow tube, it is plain that it might be inhibited at the moment when the circular fibres had contracted, and consequently the lumen would be lessened; but the nature of the stool shows conclusively that this is not the case in Bryonia, but that the intestinal increment is inhibited or stopped in diastole, as we might say, just as Galvanism or Digitalis inhibits the heart through the vagus. The intestine remaining in this way for any considerable length of time naturally causes the stool to be moulded accordingly. It is well known that the so-called secretory fibres, those which control the quantity and quality of the secretions poured out from the various glandular structures of the organism, pass to these bodies by way of the sympathetic. Those which control the intestinal secretions pass through the splanchnics. Bryonia exerts an inhibitory influence upon them as well as upon those affecting intestinal peristalsis; hence the secretions are greatly diminished, and in addition to the large size of the stool there is added dryness and hardness. From this combination of necessity springs the "obstinate constipation" of this remedy. We know that the condition of the tongue and

buccal cavity often represents the image of the gastro-intestinal mucous surfaces, and in the case of Bryonia the inhibiting fibres of the sympathetic are so affected as to produce the well-known dry mouth, tongue and lips. The action of this drug upon the sympathetic does not end here, for the secretions of the liver are interfered with, and more or less of the bile which that organ should throw out into the intestines is retained in the organism, and as you already know that the bitter taste of the bile is due to the presence of taurocholic acid, you can readily infer, and correctly, that there is a considerable quantity of this in the blood, since an intensely bitter taste is very characteristic of Bryonia. You may wonder why, if this is so, the action of the heart is not greatly slowed, for I have told you that carefully-conducted physiological experiments show conclusively that in cases of jaundice or diseases in which there is great retention of bile in the blood the slow action of the heart, and it is generally slow in such cases, is due to the action of the taurocholic acid upon the ganglia of Remak, which as you know are inhibitory ganglia of the heart. You must be aware that when an inhibitory nerve is caused to exert its function beyond a physiological limit, it is because it has been irritated, not paralyzed. While then Bryonia irritates the inhibiting fibres of the splanchnic, it does not so affect those contained in the vagus which pass to the heart, but on the contrary irritates or stimulates the opponents of the *par vagum*, the cardiac branches of the cervical sympathetic, and hence the "heart beats violently and rapidly; the pulse is full, rapid, hard and tense, at times intermittent, with strong organism of blood."

This action of the drug upon the cervical cardiac nerves would seem to be the cause of masking the action of the taurocholic acid upon the inhibiting ganglia of the heart, although it is not beyond the possible, that the intermittent action observed may be due to a temporary mastery over the heart by these ganglia due to their irritation by the acid.

You will, I am sure, recognize these cardiac symptoms as belonging to the group or class which I have told you were present in cases of lithæmia.

Ample evidence of the imperfect oxidation, incomplete disintegration, of the albuminous substances which form the gross and proximate cause of lithæmia is to be found under the pathogenesis of Bryonia.

The urine is more or less loaded with urea and uric acid. You have not forgotten, I hope, how we found that starting in with that very complex substance, albumin, with a chemical formula of  $C^{73} H^{112} N^{18} SO^3$ , was, by the process of oxidation, finally converted into the less complex substances, leucine ( $C^6 H^{13} NO^2$ ) and tyrosin ( $C^9 H^{11} NO^3$ ), and coming on down the scale, providing the disintegrating powers of the liver were not too much diminished, we obtained aric acid ( $C^5 H^4 N^4 O^3$ ), and lastly, if the condition were normal, urea ( $CH^2 N^2 O$ ). As you well know urea is highly soluble in warm water. the urine, therefore, being able to hold in solution a large amount of it. Uric acid, on the contrary, is but very slightly soluble in this menstruum. The text works and monographs tell us that the lithæmic symptom complex is caused by an undue accumulation of uric acid in the blood. This in turn is because the liver and lungs cannot reduce the albuminous matter by oxidation to its lowest common denominator, so to speak, that is, to urea. Do not mistake the true nature of lithæmia; do not consider that all of the symptoms are due to the presence of uric acid in the blood, nor that when Bryonia or any other remedy cures it, that it does so by picking up and literally carrying the uric acid out of the body. The disease most certainly originates in the nervous system. Within this wonderful portion of the organism lies the power, the controlling influence, which enables the liver to completely disintegrate the albuminous substances which pass through it. Therefore, when the nervous system has become so affected that it commences to exert such an influence upon the liver as tends to prevent its full action in the reduction of nitrogenous substance into urea, it leaves them, or a part thereof, at the intermediate stage of uric acid; a case of lithæmia is certainly developing, and the symptoms which make their appearance up to this time are as much a part of lithæmia, and an essential part, as are the first colors put on the canvas a part of the complete landscape or portrait. It is true that when the painter begins we cannot tell whether it will be a landscape or a marine view, but it is most positively the beginning of one or the other, and if never completed we will always be left in doubt as to what it might have been. Almost every case of hepatic derangement calling for Bryonia is an incipient case of lithæmia. If the action of Bryonia is continued long enough to give rise to

a certain accumulation of uric acid in the blood, then we say it is lithæmia. It is just as certainly, Mr. Jones who is coming, when his foot comes through the door as when he has entered bodily, although we may not have been able to recognize him sooner. You will find in making a selection of a remedy in lithæmia that the nervous phenomena which developed before the uric acid made its appearance in the blood, and as a result of which it does appear, will generally be the ones which will serve as a guide in the selection. After the lithic acid has been found in the blood, and only then, it is true, does the full group of symptoms which we name lithæmia, make their appearance. Remedies can certainly affect the nervous system in different ways in the production of uric acid, and after the uric acid is once developed its reflex action and symptoms resulting vary somewhat, in accordance with the manner in which the organism has first been affected in producing it. Thus in almost all cases this acid in the blood causes a feeling of fullness and heaviness in the region of the epigastrium and liver, the appearance of urates in excess, or uric acid in the urine, and the almost pathognomonic symptom of raising tough phlegm from the throat and fauces. I have not explained this symptom to you yet, or at least the way in which Bryonia produces it. You will find this pathognomonic symptom of lithæmia expressed under Bryonia in the following manner, "tough mucus in the fauces loosened by hawking. Hawking of offensive, tough mucus, sometimes in round cheesy lumps, the size a pea."

Expectoration of this sort is the kind which I consider the most characteristic of reflex laryngeal catarrh, that reflex due to hepatic trouble. Where you find this peculiar form of expectoration, that is, round, tough, cheesy lumps, you may be certain that they come from the pouches of Morgagni in the sacculus laryngeus. If you need to review your anatomy a little to locate these, it will do you no harm. Bryonia as well as all other remedies which affect the secretions of these pouches, do so through the secretory fibres of the sympathetic, which pass to them from the thyroid plexus. Let me caution you that the form of secretion referred to does not always result from a deranged liver; indeed, strictly speaking, never from a deranged liver, but only as one of the concomitants of a nervous system so affected as to produce an affection of the liver. But, I must call your attention incidentally to the fact, that, in certain forms of nervous dyspepsia this occurs, notably under such remedies as Ignatia, Agaricus and Argentum nitricum, in which case the liver may not be at all involved; but always be on the *qui vive* for hepatic trouble, coincident to, or following such a symptom.

(TO BE CONTINUED.)

## Clinical Society Transactions.

JOSEPH P. COBB, M. D., SECRETARY.

The regular monthly session of the Clinical Society was held in Parlor 22, of the Grand Pacific Hotel, on Saturday evening, April 7—Dr. George F. Shears, president, in the chair; Dr. W. H. Schrader secretary *pro tempore*. About twenty members were present.

The session was occupied with hearing the

REPORT OF THE BUREAU OF OBSTETRICS.

DR. SHELDON LEAVITT, CHAIRMAN.

The following papers were read and discussed:

- I. A CASE OF PUERPERAL ECLAMPSIA, SEVENTH MONTH OF FIRST PREGNANCY — REPEATED SEIZURES — ABSENCE OF OEDEMA — RECOVERY — DELIVERY OF DEAD FETUS THIRTEEN DAYS SUBSEQUENTLY.

Mrs. P—, æt. twenty-six years, in the seventh month of pregnancy, had been having a good deal of headache for several days, and, on the evening of March 22nd last, sent to me for relief. The messenger was her brother-in-law, and he said that she seemed to be suffering most intensely. I sent her *Belladonna* 6x.

At 11.30 o'clock, just after I had gotten into bed, he returned to say that she had gotten some temporary relief, but the pain had again returned more severely than before. Her appearance evinced the severity of the suffering, the face being flushed and distressed, but most of the time hidden in her hands. I drew from her several answers in response to questions concerning the seat and nature of the suffering, and then arose to prepare some remedies. As I did so the eyes and head turned slowly but steadily toward the right, and a general convulsion followed. After convulsive movements ceased, she, for a time, lay in a comatose state, and then opened the eyes and looked wildly at me. I spoke to her, but

my only response was a scream which attracted the attention of people who happened to be passing. Her husband's voice created further alarm, and only after considerable time could she be quieted. I continued *Belladonna* in a higher potency. About an hour later she had a second convulsion of about the same severity, which was followed by coma. After the second seizure I gave her gr.  $\frac{1}{4}$  of *Morphia*, by hypodermic injection.

The further history of the case I transcribe from my memoranda made at the time.

"March 23, 1:30 A. M. Had another convulsion; not so hard. Gave per rectum *Chloral hydrate* gr. xc., dissolved in four ounces of warm milk, in which had been dropped the yolk of one egg."

"2:30 A. M. Had another convulsion; not very hard. Gave gr.  $\frac{1}{4}$  *Morphia* hypodermically."

"4 A. M. Had another convulsion—not hard."

"7 A. M. Has had three convulsions—none of them very hard. Opened her eyes and looked at me. Temperature 100°."

"7:15 A. M. Had another convulsion of about the same severity as last. Suddenly arose in bed and vomited. Gave another injection of gr. xc *Chloral hydrate*."

"9:25 A. M. No more convulsions. Slept quietly."

"11:10 A. M. No further convulsions. Has spoken a few words."

"1 P. M. No more convulsions. Gave another rectal injection of gr. xc *Chloral hydrate*."

"6 P. M. No more convulsions. Is quite rational."

"9 P. M. Doing well. Bowels have moved; got out of bed for the purpose. Gave another injection of gr. lxxx *Chloral hydrate*, but it was retained only a few minutes."

"March 24, 8 A. M. Conscious; slept well during the night. Is very thirsty. Temperature slightly elevated; not much headache. Gave *Ars. jod.* 3x."

From this time onwards improvement was steady, and *Ars. jod.* was continued.

On the 25th I made an examination of the abdomen by

means of palpation and auscultation. No movements of the fetus had been felt since the convulsions, and my examination elicited neither motion nor heart sounds.

The patient had recovered so far as to go about the house, when, on the 4th of the present month, just thirteen days after the first convulsion, labor came on, unaccompanied by alarming symptoms. It lasted a few hours, and terminated in the birth of a dead male child, with softened brain, and peeling epidermis.

The mother is making an excellent recovery.

The following volunteer papers were then read:

II. ACRANIA—By H. P. HOLMES, M. D., SYCAMORE, ILL.—  
This peculiar case of cranial insufficiency has a history antedating delivery a little more than one year. The mother, a lady of twenty-six years and the mother of one child, a robust, healthy boy of four years of age. He has had a few spasms supposed to be due to intestinal worms, but otherwise a healthy and well-developed child. The mother, since his birth, has been one of my parishioners, and has been under treatment from time to time for dysmenorrhœa due to an ovarian irritation. A year ago last February she suffered from an attack of left ovaritis, which undoubtedly went on to supuration. My fear of pyosalpinx was not confirmed by Dr. R. Ludlam in an examination made by him April 2, 1887. Still, I was inclined to the opinion that there was a suppuration going on in the ovary, which was discharged through the uterus and into the vagina at irregular intervals in the form of worm-like bodies, as if it had been compressed in tubes and then discharged. A thorough and persistent course of treatment succeeded in bringing the left ovaritis under control, when, shortly afterward, the right ovary became affected, and went through a siege of irritation and inflammation, lasting well on to the month of August. About this time the patient was in much better health than she had been in for a long time. I had spoken of pregnancy as probably being beneficial to her case, as it would bring immunity for a period from the monthly aggravation, and, to the surprise of all parties concerned, the monthly flow did not appear at the proper time the first of September, and further experience showed the patient to be pregnant. Her period of pregnancy was quite natural, with perhaps two exceptions, considerable trouble from the so called side-ache of pregnancy, and from the very



large growth of the parts. The side-ache was brought under fair control with *cimicifuga*, and the large size was jokingly attributed to twins or triplets.

With these two exceptions, all went well until March 20th, when labor came on rapidly, the parts being dilated to the size of a coffee cup, and the bag of waters pushing down in advance in true cone shape, and doing splendid work as a dilator. When labor was far enough advanced I ruptured the membranes, when I was astonished by the enormous discharge of waters. The first gush was thrown in a large stream to the patient's feet, and continued running in a large stream for an incredible length of time. When I say that there was more than a common pailful discharged I do not begin to state the whole amount. The patient became very nervous and thought she was going to die from this discharge alone.

Examination previous to the rupture of the bag of waters had brought no definite idea of the position of the fœtus other than that of a mal-position. I could touch what seemed to be the fingers when these were instantly withdrawn from contact. As the discharge of the waters progressed I could make out an irregular shaped object, which seemed very much like the *os innominatum*, with an ear on the side of it. The ear could be plainly outlined, but just above seemed to be the crest of the ilium. Quite a little hæmorrhage occurred at this time. The presentation was vertex, and in the restitution I did not notice whether it was from the first or second position. Delivery was natural in every respect. The child was born living although it never breathed. The heart pulsated for some minutes after delivery, and there seemed to be slight struggles, as if the death was due to asphyxia.

This acranial monstrosity, of which I present a full length side view photograph, is a male child; has a fully developed figure, is fifteen inches in length from the superciliary ridge to the soles of its feet, and weighs three and three-quarter pounds. The deformity consists in the entire absence of the cranium, which appears as if recently sliced in a line from the superciliary ridges to the occiput. The surface of the cross section is covered with a thin tissue, as if attempting to heal over. In the lower center of this surface, and corresponding to the occipital foramen, are what appears to be two severed blood vessels, which leads me to believe there was an occipital tumor dependent from this point, which was very likely crushed or torn off in delivery, and these were the vein and artery which supplied the mass. In this case the hæmorrhage noticed just before delivery must have come from this part. The circumference of the head at the margin of this abnormal

surface is nine and one-half inches. All other parts are fully developed, as in a fœtus of nearly eight months of age.

The combination of acrania and Hydramnios makes this a case of more than ordinary interest. It would perhaps be difficult to say which was the prime mover in producing these results. Authorities say that hydramnios may depend upon a variety of morbid conditions affecting the mother or fœtus. In this case both were undoubtedly at fault. Dropsy of the amnion is always the result of a constitutional dyscrasia, and such was the case with this patient who is, undoubtedly, of a scrofulous diathesis.

Cases of acrania similar to this one have been reported in which it was considered as "a mark," the result of some very exciting impression made upon the mother. I remember Dr. Dowling, of New York City, presenting a similar case to the American Institute at its session in 1886, although the report is not included in the volume of transactions for that year. In his case he said the mother thought it a "mark" from the Aztec children which she had seen during her term of pregnancy. In the *CLINIQUE* for 1887, page 108, Dr. W. F. Green reports a similar case in which the supposed cause was from a shock to the mother caused by seeing a man thrown from a horse and striking squarely upon his head. In my case I have nothing to which we can attribute it. No excitement occurred to the mother after the second week of pregnancy and then the only irregularity was seeing her little boy have a spasm. It hardly seems to me that these cases can be caused by an impression upon the mother resulting in a mark upon the child.

The mother seemed to be doing well in every respect until the fifth day, when she had a hard chill, at 10:30 o'clock in the forenoon, and at 12:30 her temperature registered 104.5. This was very alarming, as we had been having an epidemic of post partum deaths from different forms of inflammation and sepsis. She was put at once upon aconite 3x, a dose every half hour, and in the evening her temperature had fallen to 100.5. From that time to the present all has gone well, and the patient is now sitting up and, to all appearances, doing as well as any case of confinement.

III. A REPORT OF SIX CASES OF DELIVERY BY PODALIC VERSION—  
By H. P. Holmes, M. D., Sycamore, Ill.—I wish to present to you to night a report of six obstetrical cases occurring in my practice in which delivery was effected by podalic version. These cases have been of so much importance to me, and so

discouraging in their results, that I wish to get all the light I can upon the subject.

My first case occurred November 11, 1883. I had been called several times in the course of two weeks to attend the mother, a primipara, in confinement, but each time proved to be a false alarm until the one alluded to above. In this case occurred a complication that was very puzzling to me at that time, and one which it has been my misfortune to meet with many times since, viz.: the position of the os being situated posteriorly, and being so high as to make it impossible to reach it for a greater or less length of time. This leaves the anterior lip drawn over the presenting part in a smooth, even membrane, and all attempts to get beyond it or make a satisfactory diagnosis of the presenting part proves futile. In this case the similarity in feeling led me to mistake the anterior lip for the placental membranes, and I attempted to rupture them with the finger nail. The positive assurance of the woman that I was hurting her was the first intimation I had of my error. It seems strange that one could make such a blunder, but I think many others might make the same error in the days of their earlier practice, and in cases which were as puzzling as this one was to me.

I was at length able to reach the os, and drew it well forward. The presenting part, which had frequently changed prior to this, now became evident as the hands and feet were felt lying closely together, and a transverse position with the ventral surface of the child downward was satisfactorily made out. As the woman had been in labor all day and was much exhausted, delivery was attempted at once by drawing down the feet, which was accomplished without much difficulty. The child was delivered as far as the hips, when further progress was delayed by the large size of the body. It took over an hour of the best work that I was able to do to deliver the body from the hips to the shoulders. In this time the child died from compression of the umbilical cord. Delivery of the arms and head was accomplished without much trouble. The mother made an excellent recovery.

My next case was one of true breech presentation, occurring on the 4th of May, 1886. The mother had given birth to seven children, and in this case the waters had discharged on Sunday, whereas delivery did not take place until Tuesday afternoon. Both feet were brought down and delivery accomplished as far as the head with comparatively little trouble. The head was firmly retained until I had given up all hopes of saving the life of the child. As soon as delivery was completed I placed the little one in a warm bath, and by sprink-

ling with cold water, and practicing artificial respiration for nearly half an hour, I was rewarded by seeing regular respirations and soon afterward hearing a faint cry from the new-comer. The babe was given arnica both externally and internally to relieve the soreness due to the rough treatment sustained in delivery. The mother and child made a fine recovery.

My third case occurred the 29th of September, 1886. This was another case of breech presentation. Counsel was called, as it was in my own family, and the attending physician had about all he could attend to. Podalic version was performed after waiting long enough to determine the fact that the child could not be delivered by the expulsive pains alone. The after-coming head was delivered with the forceps. A badly lacerated perineum was found in this case. This was immediately repaired and united nicely. The mother and child are still doing well.

Cases fourth and fifth were twins. Called November 5, 1886. Recognized a breech presentation at once. After due waiting, podalic version was accomplished with little trouble. The after-coming head was delivered with the forceps and the child found to be lifeless. The death was attributed to poor nourishment. The child was of full size, although very poor. The umbilical cord was no larger than a slate pencil, and was wound twice around the neck. While endeavoring to resuscitate the child, one of the attendants told me she felt the motions of another child, and examination proved this to be true; and not only this, but the second child was also presenting by the breech. Podalic version brought about as before, and delivery effected in good time without the use of the forceps. The perinaeum was lacerated in this case, and was immediately repaired, the mother and child making an excellent recovery.

Case six came the night of November 8, 1887. A large, fleshy woman, the mother of seven children. The surroundings were the most destitute and desolate of anything it has ever been my fortune to meet with. There was no warm water at hand until I could make a fire and warm it, and everything about the place was begrimed with filth. The child presented by the breech, and labor had driven the body downward until the feet of the child were extended above the head. Efforts to reach them and draw them down proved futile time after time. There was plenty of room to work in, but, owing to their high position, it seemed impossible to reach them. After trying seven or eight times, first with one hand and then with the other, I at last succeeded in grasping the feet and bring-

ing them down. As in my first case of the kind, the child was retained, owing to the large size of the body, until life was extinct. It might be that, had I been provided with reasonable conveniences, such as warmth, warm water, bath bowl, clean cloths, etc., the child might have been saved. The mother made a good recovery.

In my remarks on these cases I wish first to say that I have a great deal of sympathy for a physician who has a case of breech presentation to deal with. It is impossible to save every case; and, however one may feel about it and however good luck some one else may have in an individual case, the mortality on the average will be great. Prof. Leavitt, in his work on obstetrics, gives the mortality in cases of footling presentation, which seem to me to be the same as podalic version, as being one out of two and a half cases. In my first case I had a physician give me the encouraging information that he had just had such a case and had saved it. I, too, could have told him the same thing in the second case, and so on to the sixth. Both of the cases which died in delivery died from long retention, due to the large size of the body. When the strength of an ordinary sized man cannot deliver a child in time to save its life, we can rest assured, as a rule, that some one else could do no better, for the child will stand only about so much pulling from the hands of the accoucheur.

The next point I wish to make is on the use of the forceps for the after-coming head. While it is not always necessary to use them, it is always best to have them ready, for the head will frequently lodge in such a position that the child will die before delivery can be effected. Life passes quickly away at this point, and the forceps are the quickest method of delivery, and are safe to both mother and child if properly used.

As to turning the fœtus in utero, I have never been able to do it. It looks very easy when we read about it, but, for some reason or other, I could never put it into practice. I have given *Pulsatilla* and was not surprised that the children did not immediately reverse positions. A very small child in a uterus with a large amount of liquor amnii may turn itself, or be turned by the attendant, but I hardly think a large child in a small uterus will reverse position after labor has once fully started.

IV. A PECULIAR CASE OF TWINS WITH ONE DEAD AND ONE LIVING CHILD—By MRS. WILLELLA HOWE, M. D., OF SANTA ANA, CAL.  
—Case.—Mrs. C., aged twenty-five, English, a primipara, conceived with twins, boys, in January, 1886. From

the first day she was confident of a feeling of intense nausea, which continued, day and night, for four months. On May 24, she sailed from Portland, Ore., for San Francisco. The voyage was a very rough one, and the vessel tossed terribly. It was with great difficulty that she kept her berth. On leaving home the abdominal development was so slight that she had worn her usual clothing without discomfort, but during the passage she did not leave her berth. She became very much bruised and ecchymosed, especially in the abdominal region, and the abdomen increased to the size of that of a woman at the seventh month. The voyage was of three days' duration. When preparing to leave the steamer she first noticed that the entire surface of her body and extremities was cedematous. This dropsical condition continued in an increasing ratio for eight weeks more, after which it subsided rapidly with a free flow of urine. The facial expression was so changed that her best friends did not know her.

July 6, when she first consulted me, she looked like one at full term. The urine was normal in quantity and quality, and remained so until term. There followed a superficial inflammation of the abdominal integument, which caused intense burning and itching, was followed by a flaky desquamation, and did not entirely disappear until a fortnight before her delivery. This eruption was limited to the anterior surface of the abdomen. From the time of leaving the steamer she suffered from insomnia, but had never had it before. This symptom ceased with her labor, her only rest, meanwhile, lasting but for a few minutes at a time.

From being naturally possessed of a mild disposition she became irritable, fault-finding, suspicious, and altogether unbearable. This symptom also disappeared with her delivery. At about the sixth month she began to have very severe uterine contractions, and it seemed at times as if the uterus would really burst. The signs of these irregular contractions (which sometimes recurred as often as every ten or fifteen minutes) were very perceptible through the clothing.

At 3 A. M., of October 17, she was taken in labor. From the beginning the pains were intense; indeed, it seemed almost like one continuous pain, without stopping to catch her breath. The presentation was L. O. A. At 10 A. M. *chloroform* was given by inhalation to bring relief to her suffering. At 3 P. M., or in just twelve hours, the os uteri was fully dilated, and the membranes, which were very tough, were ruptured. The liquor amnii was opaque, cream-white and scant, with a sickening, disagreeable odor. The head was born at 5 P. M., and on passing my finger along the neck to find the cord it

came in contact with the head of a second, undeveloped foetus. The first child was born alive, but the supplementary foetus came down along with its body. The living child weighed eight pounds, and was normal in every respect. The other one was a still-born, undeveloped, mummified infant, of about four or five months. Its head was flat and crushed, and it had neither skin, nails nor hair. It appeared to have had no umbilical attachment to its body, but there was a shriveled remnant of a second cord on the placenta. The cord which was attached to the living child was eighteen inches long, and of the size of a goose-quill. There was but one set of membranes and one placenta.

The labor was followed by metritis with cystitis, but in spite of them she nursed her child. Her convalescence was slow, but she was around again in six weeks.

Was this a case in which the sea voyage detached and therefore destroyed one of the children, or was it a case of superfetation? We hold to the former theory.

It is possible that the renal embarrassment and consequent uræmia, with the general œdema (relieved by the diuresis), had very much to do with this result.—R. L.

The discussions of the papers were participated in by many members present, but can not be given in this issue.

*FINAL EXAMINATION IN GYNECOLOGY BY  
PROFS. LUDLAM AND BAILEY.*

1. What are the causes of Amenorrhœa, and what is the proper treatment?
2. Define endo-metritis and give its treatment.
3. What is stomatitis materna, and what is the treatment for it?
4. Give the pathology and treatment of pelvic-hæmatocele.
5. How would you treat a case of acute-retro-flexion of the uterus?
6. How often does ulceration of the os-uteri occur?
7. How would you treat a case of pelvic cellulitis?
8. Give the diagnosis of uretero-uterine from vesico-uterine fistula.
9. Name the causes and the varieties of salpingitis.
10. What are the contra-indications for the primary operation in laceration of the perineum.

## Hospital Notes.

### THE WOMEN'S CLINIC.

#### SERVICE OF PROF. E. STILLMAN BAILEY.

Notes from the sub-clinic class, February 23, 1888.

Case No. 20,168.—CYSTORRHOEA.—Mrs. C——, age thirty-seven years, married, one child twelve years, several miscarriages. Ill for several years, specific infection years ago. Present condition, after examination, cystitis, proctitis, acute ante flexion of the uterus, peri-uterine inflammation, ovaralgia, constipation.

That the case is a complicated one you will readily recognize, and, as students awaiting suggestions, I presume you have anticipated the selection of the bladder symptoms for treatment. This patient has had many physicians in the past ten years, and while she has suffered much she is still hopeful that the right treatment may yet be given her.

From her statement, which you have heard, she suffers most from the vesical disease; not only is it a chronic form of cystitis, but as we have had a sample of the urine for analysis, we find it loaded with so much of a mucus deposit that it may rightly be called a cystorrhœa. This condition, she says, has existed with but little change for the past three years. The main symptoms are frequent urging to void small quantities of urine; she must get up at night often; walking or standing produces a desire to urinate; the amount passed during the day is not large when all is collected; on standing, a deposit of 20 per cent is usually found; this is variable; sometimes it is better for a fortnight at a time, but the symptom is well-nigh constant. This deposit is cloudy, consisting of mucus, pus, and desquamated epithelium, with sometimes a trace of blood. The urine is of a dark, wine-yellow color, and is turbid. Its reaction is slightly alkaline, often neutral. The catarrhal condition has well-nigh worn her out, and as I am of the firm opinion, as expressed by Dr. McClelland, that



"a case of chronic cystitis, left to itself, invariably goes from bad to worse," I shall suggest that our attention be directed to her immediate relief. By exclusion, I rule out pyelitis in this case, hence, we have left a typical vesical catarrh, and which, fortunately, I am led to believe, has not as yet reached the third degree, as suggested in the division by Hoffman and Ultzman, viz.: "A purulent catarrh, complicated by an ulcerative process in the bladder." It is tending that way, it must be arrested. In my clinic during the winter we have had varying degrees of vesical catarrh, but no case has been so typical. Furthermore, not only are vesical diseases common in women, especially if complicated with flexions of the uterus, but the patient is herself often puzzled to know which has precedence, the bladder or uterine disorder; almost invariably through education the fault is placed with the womb. If this is made better she feels that the bladder symptoms will clear. Again, strange as it may seem, the presence of a large deposit in the urine as a constant symptom often excites no suspicion of disease.

In other cases notice is never taken, and the disease exists unknown. Another difficulty often experienced in the treatment is the modesty of the sex, nor do urinary symptoms, which are always changeable, excite, as a rule, the anxiety as in the male, and the treatment is a sort of hap-hazard one. Again, local examinations and treatment of the bladder have not been practiced to that extent that due care to ascertain the real lesion would suggest. One other reason why this class of diseases is neglected is the real chronicity of the case; if local treatment is undertaken the chances are that unless the usual symptom of pain is present, persistent, patient effort is given up because of seeming failure, or because a temporary benefit has lessened the severity of the case. Often, too, the physician cannot give the time that is absolutely necessary to care for such a case, and by neglect the patient drifts. Let me recommend a simple form of local treatment for this patient, to be pursued under the following conditions: She is a sick woman, and while it is not practical to take her from her daily work, it should be reduced to the minimum, and

she should have a nurse or attendant to wait upon her. She should have the uterus properly repositioned. She should, morning and night, get into the lithotomy position, a soft rubber catheter should be made to enter the bladder and this viscus be thoroughly evacuated. The quantity of urine withdrawn should be measured and its reaction carefully noted. The percentage of deposit should also be frequently determined. When the bladder is empty, and its diseased mucus walls are collapsed and in contact, a careful washing should be practiced. Many instruments have been devised, but I prefer the following one, which can be used in a given case and then destroyed. To the rubber catheter now *in situ*, a rubber tube could be fitted, and for convenience be two or three feet in length, at its distal extremity a funnel of glass or tin can be made to fit. Simple tepid water, a pint or so at a time, can be poured into the bladder gently, if the funnel is not held high, by removing the funnel, lowering the rubber tube, the bladder is emptied, this can be repeated as seems necessary. If the parts should prove to be very irritable, a less frequent washing may be advisable. The sense of relief by this simple method is often very great. The question is still debatable as to the value of placing medicinal substances in the water thus passed into the bladder. My personal experience is that they are valuable. After the mucosa has been cleansed the medicated substances, by contact, allay irritation, or by absorption, if the epithelium is largely removed, seem to have healing properties. For efficacy much depends upon the manner of using the medicated substances. After washing the bladder and emptying it again, a small quantity of the medicated solutions may be injected and allowed to remain. If your microscopical analysis determine the presence of bacteria, the solution to use is *Boracic acid*, grains five to ten to the ounce of warm water, three ounces to remain in the bladder. If a good deal of pain exists after using the injection a 2 per cent. solution of the *Muriate of cocaine* will relieve. If tenesmus and pain are very frequently present, I have derived excellent results from the *Fluid Extract of Ergot*, one ounce, and *Hydrastis canadensis*, three ounces, mix, and use one part

to four of water. For tenesmus vesicæ this is excellent. For simple catarrhal conditions, the watery extract of *Hydrastis* or the *Pinus canadensis*. The *Fluid Extract of Pichi*, as an injection and internally, is one of the lauded new remedies. I would also call your attention to the value of the taking into the system of a larger quantity of pure water. The various mineral waters are uniformly of benefit, and are not infrequently a great adjuvant.

The prescription, according to the rule of the totality of the symptoms, may take the catarrhal condition as only one part of the patient's illness, and, in this case, we name *Nitric acid*, 30x, and plain warm water injections as the remedies to begin with.

[Three weeks after the patient reported herself very much improved in every respect.]

Cystoscopy would be an excellent diagnostic adjuvant in this chronic case. The chemical and microscopical urinalysis would be added to by an ocular examination of the bladder walls to determine the extent of disease and the present condition of the mucus membrane. The improved and recently perfected cystoscopes of Nitze and Leiter, make it possible to conduct this through vesical examination. The new instrument is much the shape of a sound, though hollow, having in the beak an oblong mirror of quartz crystal. At the beak also is an electric lamp, mignon size. When once *in situ* the application of the electric current produces a bright illumination, the reflected image of the bladder wall is passed through a system of two strong convex lenses, and is seen at the outer end through a magnifying ocular. Thus the parts are examined as by a microscope. The success of this method is now unquestioned. Ulcerations have been observed. Calculi of various sizes, crystals studding the bladder walls, foreign bodies and neoplasms have been accurately made out by this form of examination. In the obscure forms of diseases of the bladder the systoscope offers the same advantage that the laryngoscope has for the study of the diseases of the larynx. The questions that arise against the employment of such an instrument are met by the explanation that to be really effective the urethra should be sufficiently large to admit of a sound No. 23 French. The bladder is to receive a washing, and an injection of at least five ounces of liquid; in addition, if necessary, air may be introduced also. Thus the walls may be distended and viewed. In the hands of those who have become practiced the different forms of catarrh—acute, chronic, hemorrhagic, diphtheritic and tuberculous—have been accurately determined.

## Book Reviews.

**SIMILIA SIMILIBUS CURANTUR**—by C. S. MACK, M. D. Published by Otis Clapp & Son, Boston. Addressed to the medical profession by C. S. Mack, M. D.

This brochure seems to have been born as the result of a dream or prolonged thought of the "Hamlet's Soliloquy" order. The title is followed by the doubtful mark, and if the neutral was really assumed the part has been well played. A few quotations will enable the reader to form some idea of the scope attempted. "I see nothing to accept or offer as positive, practical proof that similars cure; on the other hand I see nothing to accept or offer as positive, practical proof that they do not." "When one states publicly what he thinks of homœopathy, it is important, to himself, at least, that in doing so he be very accurate. \* \* \* My experience with homœopathy has been very limited." We are inclined to believe this statement, for surely, if he had seen more of the results under this method of treatment, he would not have wasted so much space in unprofitable words.

Mixed with the mass of chaff, we find, occasional hints which lead us to infer that the author had an intelligent idea of the governing principles of homœopathy, although he makes desperate struggles to please all parties. In alluding to the "tissue" method of prescribing, he says: "In supplying a deficiency resulting from derangement of vital processes we do not render those processes normal, a requisite to cure; nor is it curative, however useful, to neutralize or remove disease products, abnormal processes persisting."

After much theorizing, the meaning at times being most difficult to fish out, he uses arguments largely drawn from Drummond's "Natural Law in the Spiritual World;" compares the practice of our chosen method to that exercise of moral responsibility and will which prompts us to do good and not evil, and finally concludes: "While, then, I see nothing to accept or offer as positive, practical proof that similars cure, or that they do not, I am disposed to try to cure with

similars except where non-curative treatment promises more of usefulness than does an attempt to cure."—W. S. G.

**SALIENT MATERIA MEDICA AND THERAPEUTIC**—by C. L. CLEVELAND, M. D. F. E. Boericke, Hahnemann Publishing House, Philadelphia; 1888. Pp. 173.

The author has undertaken to bring to the eye of the physician, by a simple arrangement and in as few words as possible, the leading remedies and the sphere of usefulness of each. In all, 197 remedies are thus discussed. The forty-seven remedies, as designated by Hahnemann as "anti psorics," are carefully and systematically grouped. It was said by Carroll Dunham, in one of his lectures, that the task with our *Materia Medica* was to develop it, and he suggested, also, the existence of the two methods—provings and by observations of the actions of remedies on the sick (called clinical symptoms). The latter method is carried out under the following general plan:

We select *Calcaria Carbonica*, and copy the same entire:

1. **TEMPERAMENT**—Fair, plump children; leuco-phlegmatic temperament; tendency in young persons to grow fat.
2. **LOCATION AND NATURE**—Primarily upon the vegetative system, favoring deposits of earthy salts, vitiating the blood and influencing the assimilating sphere like the phenomena of scrofulosis, tuberculosis and rachitis.
3. **OBJECTION**—Large open fontanels; head large; abdomen large, hard, and much distended; painful glandular swellings, milky leucorrhœa, head and feet sweat; pit of stomach swollen like a saucer turned bottom up; profuse sweat in the mornings, or from slight exertions; sour vomiting, epileptic attacks, muscular twitchings; expectorations of mucus with sweetish taste.
4. **CASUAL**—Scrofulosis, tuberculosis, rachitis.
5. **GENERAL CHARACTERISTICS**—Children unable to walk, sluggish heaviness of body; ravenous hungry in the morning; tight clothes about the hypochondria are unendurable; painless hoarseness mornings; sore pain in chest on inspiration; great exhaustion in the morning.
6. **AGGRAVATION**—Motion in cold air.
7. **AMELIORATION**—
8. **THERAPEUTIC RANGE**—Scrofular, tubercular and rachitic affections in general. Diseases of bones, of

glands, of skin. Colypi, vesicular and pustular eruptions. Delirium tremens, sufferings of drunkards, epilepsy, chorea, rheumatism, ophthalmia, difficult dentition, chronic catarrh, especially gastric, dandruff, diarrhœa, constipation, menorrhagia, leucorrhœa. 9. ADMINISTRATION—Third to twelfth trituration.

All the remedies are considered under the general headings as above, the authors explaining the "temperaments" as "the objective expression of the individuality of a case." As a contribution, and as a help to the study and careful individualizing of remedies we believe the book will be used and appreciated.

*The Prize Essays.*—(1.) Healthy Homes and Foods for the Working Classes. (2.) The Sanitary Conditions and Necessities of Schoolhouses and School Life. (3.) Disinfection and Individual Prophylaxis Against Infectious Diseases, published by the American Health Association, are very valuable monographs on the subject; printed at Concord, N. H.

*Annals of Surgery.*—The monthly review of surgical science and practice, now in the fourth volume, is a well-sustained journal and filled with excellent articles from able writers. For a careful epitome of current literature in this field there is no journal to equal it. It is still in the hands of J. H. Chambers & Co., of St. Louis, as publishers.

*The Seventeenth Annual Report of the State Homœopathic Asylum for the Insane at Middleton, N. Y.*—Dr. Sheldon S. Talcott, the medical superintendent, has transmitted to the Legislature of New York an extremely interesting and valuable report of the workings of this asylum. As a medical expert of very large experience he proclaims to the State his law of cure. "At this asylum we use the single remedy, and each drug is administered in accordance with the totality of symptoms as presented by the patient to be prescribed for." Whole number of cases treated during the year, 642. The percentage of recoveries of number discharged, 51.33; percentage of deaths of whole number treated, 3.42; the recovery rate being the highest that has been attained since the asylum was opened for the reception of patients. The excellent work

being accomplished under homœopathic treatment is a matter of pride to the profession, and is not limited to any one section of the country.

This reprint comes to our notice; we apprehend it will be interesting to our readers:

A VERY VALUABLE LESSON FOR THOSE WHO USE ANÆSTHETICS.\*—  
By JULIAN J. CHISOLM, M. D., PROFESSOR OF EYE AND EAR DISEASES IN THE UNIVERSITY OF MARYLAND, AND SURGEON IN CHARGE OF THE PRESBYTERIAN EYE AND EAR CHARITY HOSPITAL OF BALTIMORE CITY.—I am a strong advocate of chloroform, believing it to be the most available remedy of its class. I recognize it as a powerful agent for evil, but at the same time I believe it to be the best of the general anæsthetics. In army life and in civil practice I have had a personal experience of at least 10,000 administrations, and without a death. For thirty years I have had charge of a surgical hospital service, and my daily use of chloroform has been the subject of public professional observation. Sulphuric ether I have seldom used—not 100 times in my life. In the last ten years I have not used it once. For painful operations of very short duration I use the bromide of ethyl, and for all others I use chloroform exclusively.

At the Presbyterian Eye and Ear Charity Hospital of Baltimore City, in which institution I am the surgeon in chief, I have used chloroform as often as nine times in one day. The consumption of chloroform in this hospital is computed at hundreds of pounds. A pound of sulphuric ether has never been purchased among the hospital drugs, and it is not administered in the hospital.

My rule of practice has always been to do surgical work with the least possible pain, and to refuse anæsthetics to no surgical patient. In the administration of chloroform certain rules are followed. All clothing must be loose around the neck and chest. With adults, an ounce of whisky is given in advance. In the case of persons under thirty years of age this cardiac stimulant is omitted unless the patient be feeble.

\*Paper read before the Baltimore Academy of Medicine, December 6, 1887.

In this hospital practice no precautions as to eating can be observed. The clinic is held at 2 o'clock every day. Patients are frequently sent from the dispensary to the operating room one hour after they have eaten a hearty meal. If the patient has been admitted into the hospital wards the day before operation, his dinner is withheld.

Chloroform is administered with the patient lying on his back, and as soon as narcosis is induced the pillow is taken from under his head, so that he lies in an absolutely horizontal position. Should snoring occur the chin is drawn forcibly upward. By this movement of the chin, respiration becomes immediately quiet and easy. The pulling up of the chin is a much more efficient and convenient means of pulling the root of the tongue forward than by pulling out the tongue with a dressing forceps, as is recommended by some surgeons. It is not always easy at this stage of anæsthesia to get into the mouth, as the lower jaw muscles may not be relaxed. A proper tongue forceps is not often at hand, and to tear the tongue-substance with sharp-toothed and yet slipping instruments, with the soreness and swelling which subsequently follow, is an abominable practice that should be abolished. The patient's chin and your own hands are always present, and it only needs knowledge of the method to apply it, and to secure prompt and speedy relief.

The instrument used for the inhalation is a towel folded in cone-form, with the apex of the cone open, so as to permit air to mingle freely with the chloroform-vapor. During the administration the face is closely watched by the surgeon. If the ears remain pink, the heart and lungs must work properly; therefore, there is no need for feeling the pulse. Any failure on the part of either of these organs can be seen in the change of the complexion more quickly than it can be felt at the wrist. When the conjunctiva is no longer sensitive, the patient is considered thoroughly anæsthetized, and the administration of chloroform is stopped. In eye-work the chloroform administrator must now get out of the way for the surgeon, and therefore the administration of the anæsthetic cannot be injuriously continued. Herein lies one great point of safety with the ophthalmic surgeon.

As I have previously stated, I deny chloroform to no surgical patient. Prior to the discovery of cocaine as a local anæsthetic, I administered chloroform for cataract extractions, enucleations, iridectomies, squints, lid-operations, passing of lachrymal probes, or in fact, any painful operation whatever, and even for the examination of irritable eyes in children. These patients were of all ages, from infants to octogenarians,



and, of course, represented every condition of disease and health. I repeat, that in my long experience I have never had a death from any anæsthetic, although I have given chloroform to over ten thousand persons of varied sanitary conditions; but I freely acknowledge that I have come very near having a fatal ending more than once. I have had four cases of sudden arrest of respiration, with failure of the heart's action, when death would have inevitably have been the final result had not prompt and proper means been taken to resuscitate the patient.

Experience under these severe trials has made me a firm believer in the efficacy of inverted suspension for the restoration of life in patients apparently killed from chloroform. I feel convinced, from my own experience with this invaluable method, that many of the dead from chloroform might have been resuscitated had the surgeon hung up immediately by the feet the inanimate body, instead of wasting time in applying hypodermic injections, cold-water splashings, spanking, fanning, electricity, or even attempts at artificial respiration. the remedies which text-books on surgery recommend. Do any or all of these things if you will, but hang up the patient first, and that instantly, as soon as the heart and lungs fail. It is the horizontal position that is fatal in chloroform-poisoning, and leads to death if the body is kept in it, as all the reports of fatal cases with chloroform show.

With myself it has become a matter of faith, and in suspension alone I now place my confidence. So far it has served me most successfully. Had I not used suspension in the four cases referred to, most of them, probably all of them, would have died. Then my percentage of fatal cases would have corresponded with the average chloroform mortality as reported in some of the text-books on surgery, one in twenty-five hundred cases of administration.

The suspending of the human body by the feet to restore animation in chloroform poisoning was Nelaton's great discovery, and is known as his methods of restoring patients to life when, under chloroform anæsthesia, respiration has suddenly ceased. The knowledge of and faith in this method has served me well on many trying occasions; to it I attribute my clean record of over ten thousand cases of general anæsthesia and no death.

No surgeon recognizing the responsibility of his work should ever give an æsthetic without having some one present. Should there be any sudden and alarming weakening of the heart's action and of respiration—for they always go together—without a minute's delay hang up the patient.

Should the patient be bulky, and should there not be help enough present to elevate the foot of the table or bed, throw the head and body over the side of the bed or table, letting the head hang downward, to receive all the blood that can gravitate into it, holding on to the legs so that the body shall not slide down upon the floor. Should this method of partial suspension not work well, the following more efficient plan should be adopted. When the death of an anæsthetized patient is staring the surgeon in the face any expedient likely to be useful in restoring the inanimate form to life should be immediately put into practice. Be the patient man or woman, while you stoop, throw their legs over your shoulders, hang on to their feet in front of you, and then lift yourself up. The patient's body, as you get upon your own feet, will hang from your back, with the head down. Now you have time to call for more help if you need it. Never wait for the help to come before you practice suspension, because with the moment's delay your patient may have passed from dying into death from which there will be no more earthly awakening. When too long delayed—and one minute is a fatal loss of time—suspension is as useless as the other recommended remedies, and can then do no good.

Should the case have been one of needless fright, with only weakening, and not suspension, of the vital functions, no harm has been done. The feeble pulse will always respond promptly to the suspension. It is my constant practice to use suspension for restoring strength to the heart's action after the administration of chloroform, where there is cardiac depression and weak breathing. I use this means of restoring vigor where others use the more objectionable and less efficient hypodermics of whisky or ether, or the inhalations of nitrite of amyl. It is very instructive to observe how promptly the pallor leaves the face, and how strong the pulse will become, as blood gravitates toward the head.

## Miscellaneous Items.

The post-graduate course closed March 30.—Over half a hundred students have been assigned seats for next winter's course of lectures.—These are house-cleaning days at the hospital.—Prof. Hall and President Cable, of the Rock Island Railroad, are taking an extensive trip in the West. Mr. Cable is one of our college trustees.—Dr. W. A. Dunn will locate in this city as a specialist in diseases of the throat, on his return from Mackenzie's Throat Hospital, in London, England.—Prof. Laning is to have a general medical clinic on Saturdays during next winter's course.—Dr. D. E. Lane is now at Alhambra, Cal., formerly of Rochester, Wis.—Dr. E. K. Thompson will reside at Hutchinson, Kas.—Dr. W. H. Schrader, 3900 Cottage Grove Avenue, Chicago.—Dr. R. C. Bain, recently resident physician of Hahnemann Hospital, has located at 3034 Michigan Boulevard, Chicago.—Dr. F. R. Waters is located at the corner of State and Eighteenth Streets.—Drs. G. L. Alexander and Estelle Stewart, 1888, were married February 28; they will reside at Hammond, Ind.—Dr. Alvin Boyce is at Argentine, Kas., and Dr. J. H. Gray at Wellington, Kas.—Society Meetings April 24, 25, 26, Missouri State, at Kansas City; May 8, 9, 10, Nebraska State, at Lincoln; May 2, Kansas State, at Wichita; May 15, 16, 17, Illinois State, at Chicago; May 13, 14, 15, Western Academy, at Minneapolis; May 15, 16, 17, Minnesota State, at Minneapolis; May 15, 16, Indiana State, at Indianapolis. Homœopathic Medical Society of Wisconsin May 23, 24.—The American Institute of Homœopathy will convene in its forty-first session, and celebrate its forty-fourth anniversary at the International Hotel, Niagara Falls, N. Y., commencing Monday evening, June 25, and closing Friday noon, June 29.—Dr. P. P. Gray, for several years at Honolulu, H. I., has removed to Ellensburg, Wash. Ter.—Subscribers may have forgotten that it is *this year's subscription* that is wanted.—The homœopathic physicians of Los Angeles, Cal., tendered Prof. Ludlam a most generous reception and banquet at the Westminster Hotel during his recent visit to that city; and his friends in Santa Ana presented him with a beautiful gold-headed cane.—The profession has experienced a severe loss in the death of Drs. C. R. Agnew and B. F. Dawson of New York, and of Dr. Martineau of Paris.

# THE CLINIQUE.

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Vol. IX.]

CHICAGO, MAY 15, 1888.

[No. 5.

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## Original Lectures.

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### ANATOMY IN ITS RELATION TO THE PRACTICE OF MEDICINE.

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BY PROF. C. E. LANING, M. D.\*

In presenting a paper upon the subject of anatomy to a gathering of medical men like the present one, I feel that to be practical it must not be a stereotyped lecture upon descriptive, surgical or topographical anatomy, but one which deals with the relation of anatomy to medicine in such a way as to show not only the advantage, but also the necessity, of a thorough knowledge of this important branch, to the general practitioner as well as the specialist. Almost every physician thinks he has a sufficient knowledge of anatomy and physiology to practice medicine, the general sentiment being, as has been expressed to me by physicians a number of times: "Oh! I am pretty rusty in my anatomy, but I have a good general idea of it, enough to practice medicine." Now, gentlemen, a "general" knowledge, or at least what is usually meant by this term, is not all that is necessary to have in order to make it of avail at the bedside. It is just such general knowledge which makes physicians say that the portion of the liver above the diaphragm is diseased, or that death resulted from an adhesion of the pericardium to the diaphragm, in neither case knowing the normal relation of the

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\* Written for the Illinois Homœopathic Medical Association, May, 1888.

liver or of the pericardium to this great respiratory muscle; and while I do not exaggerate one word in the above quotations, still there are few practitioners who do not have a better knowledge of the structures composing the economy and their relation one to the other. But how many are familiar enough with the structure of the spinal cord or the brain to locate with any degree of certainty a lesion of either, or to understand in an intelligent manner the *rationale* of the symptoms presented by a case of this nature? Some may reply, as others have often done to me before, "We don't care for a knowledge of the nervous system, as we never treat diseases incident thereto." What then do you treat, muscular, connective tissue or osseous tissue? No matter to what class of tissues the diseases which you treat are confined, the derangements which you are to remove have had their origin in this same nervous system, and the evidences of disease, upon which you base your choice of therapeutic measures, are for the most part made manifest through this same nervous system. If a limb is drawn out of shape by disease, how many are ready and able to say at once what muscles are concerned in producing the deformity, what nerves control those muscles, and what is the particular source or origin of the said nerves? How many are familiar with the course of the principal nerve trunks, from their origin to their periphery, and with the relations they sustain to various structures along their path, enough so to look intelligently for the causes of their disturbance?

I do not make a plea for a more careful study of anatomy upon the ground of having been a teacher of this subject, but as a practitioner of medicine, one who feels that he has devoted enough time to the study and investigation of the matter to be enabled to offer something more positive than mere theoretical views. There is much in anatomy that belongs only to the professional anatomist, and with which the physician need have nothing to do. Thus the ability to articulate a skeleton is not knowledge which is necessary to the practitioner. He scarcely needs to know to which arm a radius or ulna belongs if once out of the body, at least except in perhaps a medico-

legal sense. The relations of parts to each other in the living body is of great importance, as is also an accurate knowledge of the location of all the principal viscera, not a general one, which allows a latitude of anywhere from an inch to a foot for various structures. A physician cannot read understandingly the report of a case, if carefully and scientifically stated, unless he is thoroughly familiar with the anatomy of all the parts concerned. How readily can one follow a written or a verbal lecture upon gynæcology, or surgery, or upon the diseases of the heart and the lungs, the brain or the spinal cord, or upon anything pertaining to the organism, if he is perfectly familiar with the anatomy of the structures being treated of. I remember as if it were yesterday that when, as a student, I listened to the admirable lectures delivered upon the diseases of the heart by Prof. Asa S. Couch, that every sentence was a revelation to me, and how, as he proceeded, everything he said was as clear as could be to me, and it has never faded from my mind, while many of my fellow students, just as capable, or more so, of understanding things in general, listened in a helpless way, or took notes furiously, to afterward learn by heart and have in a parrot-like way, and practically knew nothing of the diseases of the heart after all.

The physician who is familiar with anatomy has a great advantage over his colleagues, in that he does not require half the reading to post himself or keep posted, for everything is so clear to him as he reads that it requires little study, nor does it necessitate the frequent "brushing-up" process which is otherwise requisite. If I read a thing once understandingly, I do not need to read it again; I have grasped the idea, and not the mere words in which it is clothed, and hence it is easy to retain it. As an illustration of the value, indeed the necessity of a thorough knowledge of anatomy and physiology, in order to understand matters medical, I will relate a little instance which occurred a few years ago. It was during the practitioners' course in the Hahnemann College that I, having delivered some lectures relating to the physiological action of remedies, had the good fortune to so please the physicians present that they re-

quested me to write a work upon the subject. I replied that I was not only not competent to do so, but that the great majority of practitioners were so little prepared for such a work that I would be obliged to virtually make the book one on anatomy and physiology as well. They thought I was mistaken, and, to test the case, I answered one who asked me to explain how Belladonna produced the symptom far sight, by simply saying that it paralyzed, or at least caused paresis, of the peripheral filaments of the third nerve. He admitted that this afforded him little or no clue to the case. A proper knowledge of anatomy would have made it plain to him, that since the third nerve supplies the circular fibres of the iris, the so-called constrictor pupillæ, while the radiating muscular fibres, or dilator pupillæ, are supplied by the cervical sympathetic, paralysis of the third, by allowing its opponent to act without resistance, would cause dilation of the pupil, one of the necessary acts in far accommodation. That the further action of this drug in producing far sight may be understood, the anatomical facts in the case must be clearly comprehended. The crystalline lens is moved forward and compressed by the action of the ciliary muscles, as is the case when accommodating the vision for near objects. The third nerve supplies the ciliary muscles, it being paralyzed, or in a state of paresis, it is evident that the movement of the lens which occurs in accommodating for near sight cannot take place. Just the opposite condition is caused by physostigma, because it irritates, stimulates the third nerve, and thus causes a tonic contraction of the ciliary muscles, and hence the lens is affected in such a way as to cause accommodation for near sight, and the patient has not the power to change the focus of the eye. At the same time irritation of the third nerve causes the constrictor pupillæ to be thrown into action, and the pupil contracts, just the opposite of what occurs under Belladonna, to which physostigma is a well-known antidote.

It may be asked wherein is the advantage of knowing these facts, or of having in one's mind the anatomy of the parts concerned? It must be remembered that the pupil may be dilated in different ways, from different causes, and the

ability to determine the cause of a given symptom must be recognized as of importance. Suppose now that the pupil is dilated in another case in which the third nerve is not involved, as, for instance, occurs under the action of Cina. How will our anatomy help us out on this? It will not only explain how it can be, but enable us to remember the facts in the case by the one hearing. Cina dilates the pupil in a reflex way, that is, it causes an irritation of the sympathetic nerves of the stomach and intestines, and this irritation is conveyed through the so-called *rami-communicantes* up to the cervical ganglia of the sympathetic, and from this point arises the fibres which, as we have seen, control the dilator pupillæ. These nerve filaments, being thrown into an abnormal degree of activity, cause the pupil to dilate, and for just the opposite reason that Bell. causes the same symptom.

If now we are acquainted with the anatomy of these cases, we at once understand why the Cina patient does not have difficulty, or at at least not nearly so much as the Belladonna case, in accommodating the eye to near objects. Not affecting the third nerve, Cina does not interfere with the action of the lens in accommodation, as does Belladonna, since the ciliary muscles are left free to act. I might go further, and show how anatomy enables us to follow the similarities and differences between these two remedies, showing why that, while both have or produce a dilation of the pupil, the one causes the coats of the arteries to be relaxed and the pulse full and bounding, while the other contracts the circular muscular tissues of the arterial walls, and consequently has a pulse which is "small, but hard and accelerated."

If thoroughly familiar with the anatomy of the tissues involved in the above illustration, any one hearing this will have the facts of the case indelibly impressed upon his mind, while if not, the whole thing will seem nebulous and illy defined. What is true in this case is true all through. The physician who is perfectly acquainted with the anatomy of the liver, and can follow out the various vessels and nerves which enter and leave it to their ultimate origin or termination, will have little, if any, trouble in remembering the symptoms of cirrho-



sis of that gland. He can at once comprehend how, if the connective tissue entering into its formation undergoes hyperplasia, the capillaries in the liver, which represent the breaking up of the portal vein, will be compressed, and consequently a stasis of blood occur throughout the entire portal system, giving rise to ascites, constipation, gastric catarrh, etc. It at once becomes plain why this gland should have the irregular, uneven outline which gives it the name of hobnail liver. The connective tissue not being developed evenly throughout, causes contraction of some parts more than others, giving rise, of course, to elevations and depressions upon the surface of the organ. It will readily be understood why ataxic symptoms result when there is a hyperplasia of the connective tissues in the column of Goll, if the physician is only familiar with the anatomy of the cord. How easily, by the same token, will he comprehend why the "reflex" is diminished or entirely absent in such cases.

The anatomist needs to be told but once how the pain under the right scapula, which occurs in provings of *Chelidonium* and in certain hepatic diseases, is conveyed there, for he has clearly in his mind the great splanchnic and its ramifications, by means of which the pain is reflected. He can see at a glance how, through the same nerve, certain gastric disturbances give rise to a more or less continuous ache in the dorsal region between the scapulæ.

While I do not wish to encroach upon the territory belonging to any other department, yet the practical relationship which anatomy bears to all branches of medicine can be shown in no way so well as by illustrative cases from practice. A patient presented himself at my office some months ago, suffering from a peculiar condition, which I certainly could not have diagnosticated, to say nothing of the proper treatment, had I not been familiar with the anatomy and physiology of the parts concerned.

The patient was a young man seventeen years of age, and as he entered my consultation room I at once observed that his respiration was rapid and superficial. The air passed through the lips during *inspiration* with such force as to

cause almost a whistling, while during *expiration* it did not come out with so much force, and the expiration was more prolonged than the inspiration. The countenance was somewhat pale, and wore that peculiar look of anxiety which almost always accompanies dyspnoea. I at first thought there must be some cardiac lesion, but found the pulse steady at 80 per minute, falling to 75 in a few minutes, at which rate it remained. The action of the heart was good, and there was not the slightest evidence of any valvular lesion. The respirations, of the character already described, were 45 per minute.

Upon inquiry I ascertained that on Friday night, about 12 o'clock, one week previous to the date of his visit, he had awakened with a sense of suffocation, and sprang out of bed, calling for his mother, saying he was dying. His breathing was at that time, as near as I could learn from himself or his mother, the same as when he presented himself to me for examination. When the attack came on a physician was hastily summoned who gave him some medicine without pronouncing as to the nature of his difficulty. He obtained no relief that night, and the next day called another physician, who diagnosed it as "biliousness," and presumably prescribed for that very accommodating malady.

Doctor No. 2, not being successful in relieving the peculiar bilious (?) attack, the patient drifted into my hands. He complained of no pain, only a desire for air, more than he could get even at 45 respirations per minute. Inspection of the chest wall, as well as auscultation, revealed the fact that the upper portions of the lungs were doing almost all of the work. The chest walls were distended very much, there was but slight contraction and expansion occurring during respiration. By this time my mind's eye had traveled over the pneumogastric nerve, and recalled the fact that its pulmonary filaments, when irritated, caused *inhalation*, while irritation of its superior laryngeal branch caused *expiration*. In this case the inspiratory act was more sudden and violent than was that of expiration, pointing conclusively to the fact that the pulmonary filaments were involved. The next point was to determine whether the lesion affected the peripheral filaments or the center of origin in the fourth ventricle. How can this be done? Very easily. I gave him some *Veratrum vir.* tinct. and ordered him to take three drops of it, and, if he did not find relief, to repeat the dose every half hour until he had taken three doses. If no benefit or relief was experienced by that time, he was to stop it, and report to me. The report was that fifteen minutes after the first dose he felt easier, but continued to take the medicine until he had taken three doses, when he felt

much relieved, the respite lasting for several hours, when he was again as bad as ever. This of course showed that it was the peripheral pulmonary filaments which were affected.

It is unnecessary to go any farther into the details, as regards the diagnosis or therapeutics of this peculiar case, in this paper, but I am sure that, had not the anatomy of the parts implicated been well in mind, I could not have arrived at any satisfactory conclusions as to the nature or location of the lesion, and might have been obliged to have fallen back upon "biliousness." I am aware that many of the practitioners in our school do not value very highly the ability to diagnose a case correctly; and while I cannot say, as do our brethren of the old school, that "a case well diagnosed is half cured," still I invariably feel that a satisfactory diagnosis—one made upon scientific principles—is a very good plank to stand upon while searching for the *similimum*; and I am sure, from experience in my own practice, and from observing cases seen in council with other physicians, that no diagnosis at all, or an erroneous one, many times prevents the physician from selecting the appropriate remedy, for the reason that, not knowing the nature or location of the lesion, he overlooks or misinterprets valuable objective, if not subjective, symptoms. And this leads me to make the assertion that one cannot be anything but a "book" diagnostician, if he be only a "book" anatomist. Many times, while demonstrator of anatomy, have I had students in the dissecting room reel off, at a twenty-knot an hour rate, word for word, all Gray had to say about the median nerve, or the ulnar, or some other structure, and the next minute, upon my picking up the said nerve, or pointing to the tissue described, and asking, "What is this?" have them say, "I don't know, sir." Such anatomy, gentlemen, never will do as the groundwork for a diagnosis.

Let me emphasize this: It is not a *general* knowledge of anything which makes a man skillful, and the man whose tendency, or habit, is to generalize, is out of his sphere as a practitioner of medicine. That *special* knowledge in medicine is what is needed is certainly evidenced by the large number of specialists who have developed within the past few years; and it is a noteworthy fact that the best of these men commenced the study of their specialty by making themselves thoroughly familiar with the anatomy of the structures involved in the class of diseases which they treat.

As I have already stated, anatomy, or rather a knowledge of it, makes all things pertaining to medicine more easy of comprehension. If a student is told that primary pneumonia

almost invariably begins in the base of the lungs, he may remember it for a time, or even may retain the fact as stated to him indefinitely; but how much better does he understand and remember it if at the same time he is told the anatomical reason for this fact. Equally true is it that the student or physician will better remember and understand the various symptoms of a cardiac valvular lesion if he is acquainted with the anatomical basis of the whole thing. It is needless to multiply illustrations, for they might run on to infinity. One word more in regard to the importance of diagnosis. I don't mean that a diagnosis will help a physician to prescribe if the name of the disease is but an empty name to him, for it should convey to his mind the nature and location of the difficulty. If some physicians were told that their patient was suffering from an attack of *polio-myelitis anterior acuta*, they would find little material assistance from the diagnosis as regards the making of a prescription; but to a physician who from the diagnosis could at once locate the lesion, and who understood the nature of the pathological changes which take place in this disease, and knew the histological elements involved, to such a physician, I say, its diagnosis might be of incalculable value.

The many ways, the many times that a proper, practical knowledge of anatomy may and will assist the physician are far too numerous for one to attempt to enumerate in a paper of this scope. The fact that similar, or apparently identical objective and subjective symptoms have at times an entirely different meaning, according to the lesion giving rise to them, makes it imperative, from simply a therapeutic standpoint, that the physician should be able to properly interpret them, and this he cannot do unless he has more than "a general knowledge of anatomy, enough to practice medicine."

While I know it is not practical, at least for many, still I am sure it would add much to the ease of the practice of medicine, as well as insure greater accuracy in both diagnosing and prescribing, if every physician would at least every two or three years make a careful dissection under a competent demonstrator of an entire subject. Does it seem like the ways of a scientific man to be constantly reading up on the ills of the body and the remedies therefor, and at the same time forgetting as rapidly as possible all about the mechanism of the structure to be treated? Let us keep clear in our anatomy, gentlemen, and as a rule our reports of cases will be more clear and more readily understood, and in this way we shall each help to add to our common knowledge.

## Clinical Society Transactions.

JOSEPH P. COBB, M. D., SECRETARY.

The Clinical Society convened in regular session at 8:30 P. M. May 5, at the Grand Pacific Hotel. The meeting called to order by the first vice-president, Dr. J. D. Craig. Twenty members were present. Drs. Lucy Waite and Kate Hickox were proposed for membership by Drs. H. B. Fellows and E. S. Bailey.

The report of the evening was submitted by

### THE BUREAU OF CLINICAL MEDICINE.

DR. W. J. HAWKES, CHAIRMAN.

#### CLINICAL CASES WITH VERIFYING CHARACTERISTIC SYMPTOMS.—

BY DR. W. J. HAWKES.

*Case 1.*—**EMPHYSEMA**—*Nux vomica*.—This patient has been ailing for several years, and during the past two years has been unable to sleep more than one hour at a time. For the past six months he has been unable to lie down five minutes continuously on account of the difficulty of breathing.

A diagnosis of emphysema was made by Prof. Crawford in a sub-clinic at the Hahnemann Hospital. The indications as we find them at present are: First, extreme difficulty of breathing and labored respiration, with, at the same time, lack of motion in the walls of the chest, an expression of great anxiety, and the general symptoms of emphysema.

The peculiar features of the case are that the patient is especially restless during the latter part of the night, beginning at 2 or 3 o'clock and continuing until 6 or 7 o'clock. In addition to this there is chronic constipation, with frequent urging without result; irritability of temper; dyspepsia, characterized by great sense of weight in the stomach an hour or so after eating. To repeat the characteristic indications for

*Nux vomica*, the 3 o'clock A. M. aggravation, the irritability of temper, the constipation with urging, without result; the headache with feeling of distention; head feels enlarged. The question was asked by several of the students, "What has *Nux vomica* to do with emphysema?" My reply was, "Nothing to do with emphysema, but everything to do with this individual patient." Wherever this group of symptoms exists *Nux vomica* will invariably benefit the patient. The result in this case was that the patient reported, a week after the beginning of the use of the medicine, that he was able to sleep four hours at a time; for the past three days he has felt better every way; less irritable; stomach and bowels more natural and comfortable; irritability of temper less; headache less, and general improvement noticeable. This patient reported, week after week, steady improvement in every particular. The remedy was prescribed in the 1 m. potency, three powders being given at the first prescription. Each week since he has had placebo, the improvement going steadily on, until he left the city to live in New Mexico. The action of the medicine in this instance was marvelous.

*Case 2.*—*DYSPEPSIA.*—Patient, thirty years of age, has had dyspepsia for several years. He now complains especially of constipation, sore aching in the stomach, with sense of great weight; acidity of the stomach, with sour belching; constipation, with desire for stool without result; severe headache; heaviness in head; restless at night between 2 and 6 A. M.; sleeps soundly until about 2 o'clock, when he awakens, and is restless and uncomfortable until 5 or 6 A. M.; is very cross and irritable; impatient; cold feet; in short a perfect picture of a dyspeptic, and especially of a *Nux vomica* dyspeptic. February 21, he received *Nux*, 1 m., three powders; on February 9, he reported not much better but less nervous, and bowels more regular. February 23, he reported considerable general improvement. March 1, reported almost well. Patient has not since been seen. The same group of symptoms as in the other indicated *Nux vomica*, and when this group of symptoms is observed in a patient it is an absolute certainty

that *Nux vomica* will relieve the patient. No medicine was given after the first visit.

*Case 3.*—CATARRH.—*Pulsatilla*.—This patient, a little girl about twelve years of age, has had catarrh for three years; is troubled with sore throat and difficulty of breathing; discharge dropping from posterior nares is thick and yellow; bad taste in the mouth in the morning; desire for acid food and pickles; disgust for meat, especially fat meat; severe headache; congestion to the head; worse in the morning and in a warm room, and better in the open air. Patient is inclined to be despondent and low-spirited; her mother says she can scarcely speak to her without making her cry; has sad and despondent moods. The symptoms call for *Pulsatilla*, which was prescribed in 200th potency on November 10, the characteristics being the yellowish, thick discharge; bad taste in the mouth in the morning; desire for tart and sour food; disgust for fat food; headache better in the open air and worse in a warm room; low spirits and despondency; tendency to tears. November 17, the patient reported that the headache was much less; other symptoms much the same; *placebo* was given. December 1, patient reported about the same, not much improvement since the last visit. *Puls.* 1 m. was prescribed. December 8, generally marked improvement was reported. December 15, still further improvement was the report. December 22, the patient reported herself almost well. This was the last seen of her.

*Case 4.*—RHEUMATIC PAINS IN THE JOINTS.—*Pulsatilla*.—Trouble is of one year's standing; a girl twenty years of age; pain in her joints is better from motion and worse in hot weather; there is a catching pain in the left side on walking fast; the pains shift rapidly from one place to another; she complains of much headache, which is better in the open air and worse in a warm room; freedom from pain at night; suppression of the menses for the past four months. This suppression was caused by getting wet, especially her feet; severe cough; worse during change of weather from dry to

wet. Patient is very low-spirited; cries while giving her symptoms. The characteristic symptoms in this case are, first, the shifting nature of the pain; pain flying from one part of the body to another. Rhus and Mercurius both have rheumatic pains worse before and during a storm or damp weather, but only Puls. has the pain flying quickly from one place to another; then the catching pain in the left side, on walking fast, is particularly characteristic of Puls.; the headache better in the open air and worse in a warm room; the low spirits and weeping mood; the amenorrhœa from getting the feet wet. Puls. 1 m., three powders, was prescribed October 13. October 20 the report was improvement in all respects except the cough. Placebo was given. October 27 the report was, that the cough was better; some aggravation of the headache in the afternoon. Placebo. November 10, general improvement. Placebo. November 17, complains of flushes in the head and face; other symptoms better, still the menses have not reappeared. December 1, all symptoms have disappeared excepting the amenorrhœa. The patient has not since reported.

*Case 5.*—A little girl, aged thirteen years, complains of being extremely nervous, great weakness and prostration; frequent fainting fits; faints in school. There are many symptoms of the approach of the menstrual period. Patient complains of frequent headache, especially in school and indoors, more especially in a warm room; is extremely low-spirited and despondent; no appetite; when she does eat wants her food sour; is especially fond of pickles; she particularly dislikes meat, and especially fat meat; the thought or sight of cooking of food nauseates her; she feels better in every way, and especially the headache, out doors in the open air; all her symptoms are aggravated in a warm, close room. December 1, received three powders of Puls. 1 m. Characteristic indications in this case being the low-spirited and crying mood; aggravation of all the symptoms in a close, warm room, and relief of same in the open air; the absence of appetite; the disgust for fat food, and the threatening approach



of the menstrual period. Where this group of symptoms exists it is an absolute certainty that Pulsatilla will relieve the patient. December 8, the patient reported general improvement, that the appetite was better, and she was much more cheerful. Placebo was given. December 15, general marked improvement. Placebo. December 22, considered herself well and was discharged. Placebo.

*Case 6.*—Young girl, aged fourteen; has had a cough for two months; takes cold very easily; is very nervous and has a severe headache; jerks and starts while sitting still; pain on the least exertion of the left side just above the crest of the ilium; headache better in the open air and worse in a warm room; loss of appetite; heavily-coated tongue; low-spirited and cries very easily; all her symptoms are better in the open air and worse in a warm room. February 23, received Puls. 200, three powders. March 1, reported that the cough had almost disappeared; pain in left side had disappeared; headache gone; tongue comparatively clean; generally better. Received placebo. March 15, not so well on account of having taken cold in the rain and getting her feet wet, has had fever and chills daily for several days; hands cold and face hot. Prescribed aconite 3d, to be taken during the day. I question the wisdom of prescribing aconite or any other remedy at this stage in these cases. I am satisfied that when in the treatment of a chronic case of any character, marked improvement has followed the administration of a well-selected and clearly indicated remedy, it is unwise where, as in this case, a cold has been taken during improvement of the chronic conditions, to prescribe aconite or any other remedy. I am convinced that better results will be obtained by allowing the case to go on under the curative action of the remedy originally selected for the chronic condition. The acute symptoms in such cases, resulting from what is called "taking cold," will, in a healthy individual, gradually disappear without medicine, and I believe they will disappear also in such cases as the one we are discussing, without the interference of any other remedy than the one already acting in the cure of the chronic

condition. This case reported March 22 that there was a general improvement, but complained of chills in the chest, and still had some heat in the face. *Placebo* was prescribed. March 28, patient reported little improvement since last visit. Puls. 1 m., three powders, was prescribed. April 12, patient reported herself so much better in all respects that she regarded herself well. Received placebo, and was discharged.

*Case 7.*—Young woman aged twenty, irregular menstruation; patient began to menstruate at fourteen; was regular until three years ago, when she took a severe cold from getting her feet wet at a critical time. She now complains of great bearing-down pain in the small of the back; severe headache; loss of appetite; sourness and burning in the stomach; coated tongue; bad taste in the mouth, especially in the morning; low-spirited and despondent; disgust for fat food; great relief of all the symptoms, especially the headache, in the open air, and aggravation of the same in a warm room; is often sick in bed two weeks at a time; the menses irregular and postponing during the past three years. March 1, received three powders of *Puls. 1 m.* March 8, reported much better for the past three days. Received *placebo*. March 15, took a severe cold and was sick in bed yesterday; complained of being drowsy, weak, no ambition; pain in the lower limbs, which shifts readily from place to place. In this instance no notice was taken of her having taken cold, and *placebo* was prescribed. March 22, reported much improved in every way. Received *placebo*. April 12, improving steadily in every particular; *placebo*. This was the last seen of this patient.

*Case 8.*—JAUNDICE AND DYSPEPSIA—*Lycopodium*.—Patient aged thirty-one; has been troubled with jaundice and dyspepsia for several months. In addition to these symptoms he complains of great distress and distention of the stomach, with much belching of gas; dryness of the mouth; white coated tongue; complains also of feeling full immediately upon eating a small quantity, although he began the meal with a good appetite; this is followed by great rumbling in the bowels in

the left side; pain in the small of the back, relieved by urinating and aggravated by retaining the urine; observes a reddish, sandy sediment in the urine; feels tired and exhausted after 4 o'clock P. M.; all his symptoms are aggravated between 4 and 8 P. M.; complexion of the face yellowish; whites of the eyes yellowish, with generally jaundiced appearance. The characteristic symptoms in this case are, first, the very unwholesome, sallow complexion; the distension and sense of satiety after eating but little; pain in the back, aggravated by retaining the urine, and relieved by passing the urine; the reddish, sandy sediment and the aggravation of all the symptoms after 4 o'clock P. M. *Lyc.* 1 m., three powders, was prescribed. *Lyc.* and *Nux vomica* are two of the most valuable and often indicated remedies in the treatment of patients suffering from dyspepsia. Among the distinguishing symptoms of the two remedies are, first and most important, the period of aggravation, the *Nux vomica* patient being invariably worse from about 2 or 3 A. M. till daylight, while the *Lyc.* patient is invariably worse from 4 to 8 P. M. No knowledge of pathology has thus far been able to tell us why this should be the case: that one dyspeptic patient should be in especial distress from 2 to 4 in the morning, while the other will have his period of aggravation from 4 till 8 in the afternoon. Nor has our best knowledge of *materia medica* and the pathogenesis of drugs enabled us to tell why *Lyc.* should cure one case and *Nux vomica* the other; or why *Lyc.* should utterly fail in the *Nux* case, and *Nux* utterly fail in the *Lyc.* case, but the facts exist, and facts are staunch friends and stubborn enemies. *Nux vomica* is a remedy known to and used by all practitioners of homœopathy. This is not the case, however, with *Lyc.*; the great value of *Lyc.* as a curative agent is unknown to a majority of homœopathic physicians; that is, all those who have no faith in the higher potencies, and who confine themselves exclusively to the extreme lower potencies, because *Lyc.* is a drug that is practically inert in the crude state and in the lower preparations. The United States Dispensatory says of it that it is used by pharmacists as a powder to prevent pills adhering together in the box, and to powder chafed infants.

This is all that is known of this powerful agent by our old-school brethren, and those of the new school who use no potency higher than the 6th. This patient received *Lyc.* 1 m., three powders, September 1. September 8, reported marked improvement; improvement was visible in the changed complexion of the patient. *Placebo.* September 15, the same report of steady improvement. *Placebo.* September 22, patient almost well. *Placebo.* September 30, patient discharged, cured.

*Case 9.*—CHRONIC INFLAMMATION OF THE KIDNEYS.—Patient forty-four years of age; has been troubled for a number of months with great pain in the small of the back and in the abdomen; at times this pain is so severe she can scarcely breathe; pain extends from the region of the kidneys toward the bladder; pain in the back greatly aggravated by being obliged to retain the urine after desire to void it has been felt; the passage of the urine relieves this pain; reddish, sandy sediment in the urine; appetite poor; little satisfies, producing a sense of satiety; bloating in the region of the stomach till she is obliged to loosen her clothing; aggravation of all her symptoms after 4 o'clock in the afternoon. December 8, received *Lyc.* 200. December 15, reports marked improvement; has had pain twice since beginning the use of the medicine. *Placebo.* March 8, the patient reported entirely relieved from pain since last visit till yesterday, a period of nearly three months. The pain returned yesterday, beginning in the back and right side, extending to the left. Prescribed *Lyc.* 1 m., three powders. March 15, patient reported herself well and was discharged.

*Case 10.*—HEADACHE—*Lachesis.*—Female patient, aged forty-three; complains of a terrific headache in the left frontal region, and the left mastoid region of the head, and describes the pain as like that of a felon. Had the same trouble nine years ago, and it then left her partially deaf. The feeling at first as though the hair was being pulled; head extremely hot when aching; head feels full and as though there was a pro-

jection outward of the left side of the frontal bone; also as though the mastoid region of the same side was forced outward. The patient insists that the bones in these regions are actually forced outward. She says the pain is so terrible that she would rather die than continue to bear it. She has been unable to sleep any length of time for weeks; her expression is that of the most exquisite suffering. It is about the climacteric period; much heat about the head when aching severely; on waking from the short periods of sleep she is enabled to enjoy, her headache is invariably worse; she complains also of an uncomfortable, choking sensation, which is greatly aggravated by the touch of clothing; she cannot tolerate the slightest pressure on her neck; the same intolerance of clothing about the chest and the abdomen is experienced. These symptoms of intolerance of clothing about the neck and body are very marked; complains of chilly feelings between 5 and 6 in the evening. The characteristic symptoms in this terrible case are, as usual, the peculiar ones, namely: headache and all symptoms worse after sleep, cannot tolerate the pressure of clothing about the neck or abdomen, and the climacteric period. Prescribed *Lachesis* 1 m., three powders. January 19, patient reported marked improvement in every respect; that feeling of projection of the frontal bone not so prominent. The patient now sleeps well; she says the third day after commencing the medicine she began to improve, and the improvement since then has been to her as marvellous as grateful.

I would call attention to these 1000th preparations of Boericke & Tafel, and urge all who have no confidence in the efficacy of such potencies to make tests with them. That they are as labeled this responsible firm assures me they are ready to make affidavit, and I give my assurance that they cure where the cruder preparations fail, and that in my experience they have never failed, when clearly indicated, to relieve the patient. To those who have no faith in dynamisation, and who fear to test such potencies on account of the danger to their patients, I would say, that it is not necessary to make the test in seriously sick cases. Chronic cases, in which a day,

more or less, will make no difference, and in which it is perfectly safe to wait, may be selected for the experiment.

*Discussion.*—DR. J. D. CRAIG.—I can say that I have verified these symptoms time and time again. I often find, however, that an important symptom of the group may be lacking, *e. g.*, the yielding disposition of *Pulsatilla*.

I remember the case of a lawyer, who was subject to severe headaches, and consulted me while suffering with this headache. During my examination he kept pulling at his shirt-collar, and in reply to my questions he informed me that the collar always bothered him while suffering with the headache, and never at any other time. *Lachesis* cured that headache.

Formerly *Lycopodium* invariably failed me, and I believe it was due to the poor quality of the preparation, as it is now one of my most precious remedies.

DR. W. E. REED.—This report recalls to my mind a case of enuresis in a child of eight years, which had been under old school care for two years. Opium had been used with some relief until its toxic symptoms were developed, when it was changed for the bromides, which were pushed until bromism was induced. My first prescription was made before seeing the child, and *Pulsatilla* was given. There was some slight improvement, but not enough to satisfy me. I learned on further examination that the child would come in with a ravenous appetite, but on tasting food would be satisfied; that there was a distended abdomen, and much rumbling in the bowels after eating. I prescribed *Lycopodium* 1m. The child was free from the difficulty for two weeks. At the end of a month I learned that the trouble was returning. More of the same medicine was sent, and six weeks later the report came that the child was entirely well.

I also recall a case of diphtheria, in which several homoeopathic remedies had been used in rotation. It was a genuine case of diphtheria; worse on the left side, pain and distress all worse after sleeping, and horrid visions on closing the eyes. One dose of *Lachesis* was all that I gave. The patient slept through the night very well, and was very much

better in the morning. Since that time she has hardly had a sore throat, although she had previously been troubled with a chronic sore throat the greater part of the time.

DR. GEO. F. SHEARS.—I have found that in prescribing Pulsatilla it is not necessary for success that the patient should be of a fair complexion, with a yielding and tearful disposition. I have wrought cures with the remedy in cases where the reverse obtained.

DR. REED.—I have found that patients ordinarily of a cheerful disposition, who become peevish, are helped by Pulsatilla.

DR. ARNULPHY.—In the case of emphysema given in the report it would be interesting to know what stage the patient had reached; whether the constipation was due to venous stasis, and if the cure was afterward verified by a physical examination.

DR. HAWKES.—The diagnosis was made by Prof. Crawford in his sub-clinic, and the symptoms, as observed in my clinic, were certainly those of emphysema. No physical examination was made at a later period. The case certainly looked hopeless when first seen, but he reports from New Mexico, however, that he is almost well.

DR. R. LUDLAM expressed his gratification in having listened to the reading of the report for the evening. With the multiplication of specialties we are apt to drift away from the consideration of therapeutical questions, and to lose sight of the old-time and trustworthy indications for internal remedies. It is a wholesome thing for us all that our society works through bureaus which are representative of the several branches of medicine and surgery, and that their monthly reports not only bring what is new to our notice, but also serve to remind us of the claims of remedies which are likely to be overlooked, if indeed they are not forgotten.

Concerning the case of emphysema reported upon, he did not doubt the correctness of the diagnosis, neither could there

be any question of the relief that followed Dr. Hawkes' treatment of the case. Both of the witnesses to the facts are competent and reliable; but, if we are to consider the case as one of absolute cure, it is quite another matter. Dr. Arnulphy's remarks are pertinent and suggestive, for, unless the physical signs of emphysema were disposed of, the mischief was allayed but not cured.

The clinical point in this case is a reminder that the gastric and alimentary complications of thoracic disease often cause the largest share of the suffering, and not unfrequently afford the best and most reliable indications for the choice of the remedy. Whoever has treated pneumonia and bronchitis, especially the capillary bronchitis of infants, must have verified this fact.

It will not be doubted that the reliability of the preparations of *Lycopodium* is very much increased by the labors and skill of Thompson & Capper, of Liverpool, and Prof. Smith, of Cleveland. As a rule he thought the matter of temperament should have very little weight in the choice of a remedy, for unless the symptom was the reverse of the temperament it had almost no clinical significance. Whether the "placebo" method, with a dose of medicine at the range of a week or two, would answer as well in private practice as in Prof. Hawkes' hospital clinic might be a serious question.

DR. W. J. HAWKES said that he did not wish to be understood as an advocate for the use of the high potencies exclusively, for such was not his position or preference. Concerning the "placebo" he insisted that what the patient needed, and what he paid for, was *advice* and not *medicine*, and therefore he could not see that there was any valid objection to the practice. The sick came to the physician for a cure, not for drugs.

I. POISONING BY EATING WILD PARSNIP [*Pastinaca Sativa*]  
—TWO DEATHS AND ONE RECOVERY—BY DR. M. JAY BROWN, OF  
SALINA, KAS.—April 3d I was notified that two boys were found dead on the prairie near the banks of the Mulberry in this (Saline) County, Kas. On the morning of the 4th I



arrived at the residence of Fred Leis, where I learned the following:

About 8 A. M. the day previous, Mr. Leis sent his three sons out to herd cattle. Their ages were twenty, seven and five years, respectively. They were perfectly well when they left home. At noon they did not return home for dinner, and at 2 P. M. their little sister was sent out with a lunch. In searching about where they had formerly taken their lunch, she found her brother, aged seven, lying on his face, dead. She returned home and notified her parents, and search was made for the other two. They were found about one hundred feet away in the tall weeds; the eldest dead, and the youngest lying across his body apparently dead, but found to be partly unconscious and very weak.

There was no evidence whatever of vomiting, purging, spasm or contortion of the features, neither could any sign of a struggle be seen. It was truly mysterious. I summoned Dr. E. D. Bradley, of Brookville, Kas., who conducted the autopsy on the younger of the two dead. The following facts were found:

The stomach contained about one ounce of wild parsnip, a portion of which was partly digested, the rest remaining unaffected by the gastric juices. The coats of the stomach were very much congested, and about the cardiac end, extending nearly to the pyloric orifice, were large, irregular patches, very highly congested. The entire intestinal tract was more or less congested as low down as the sigmoid flexure. The spleen was congested and full of very dark blood. The peritoneum was also congested over the greater portion; kidneys and liver not abnormal.

It might be well to state here that I have since been informed that the two who died were compelled to leave home in the morning without breakfast, hence their hunger and trial at this kind of food.

Dr. Bradley gave me the following information in regard to the youngest boy, who recovered. He saw him late in the evening on the day in which he partook of the wild parsnips. The boy had been unconscious; had been vomiting occasion-

ally. The matter ejected consisted of what had been eaten in the morning, mixed with mucus and water. His pulse was 140, and his respiration 38. There was much prostration; an emetic was given; heat and stimulants administered for prostration. I saw the boy the next morning with Dr. Bradley; no symptoms remaining other than slight weakness. He made a full recovery in four days.

In the case of the boy that recovered, very little could be learned; his statement was that what they had eaten they had dug out of the ground, and it tasted sweet. He had eaten very little, as he said, which, no doubt, is true. The quantity, however, was sufficient to arrest digestion; there was no marked thirst.

Since this occurrence, I have been informed that a number of people have lost their lives in this country from the same cause; one instance in which five lives were lost from a single meal where they had partaken of the wild parsnip with other food. The duration of their illness was from one to three days. What care they received and the symptoms they presented I could not learn, as there had been no autopsy held on any one of these cases; there was no one who could give me any information as to the characteristic effect of the poison. In our case the examination was confined to the abdominal viscera alone.

It is a well-known fact that the variety of parsnips commonly cultivated for table use, if allowed to run up to seed for several years, becomes very poisonous, and proves fatal to cattle and sheep if fed to them. This I know from personal observation, as I have seen its results at my former home in Northwestern Ohio. [There are several cases of poisoning from the use of this plant in "Millspaugh's Medicinal Plants." The physiological action of the drug is given as having illusions of sight, dilated pupils, vertigo, difficult breathing, week, slow pulse. All the symptoms of the drug point to severe gastric irritation, with reflex action upon the brain and spinal cord.—E. S. B.]

II. NECROSIS OF THE FEMUR—BY DR. A. M. LINN, OF DES MOINES, IOWA.—On November 5, 1884, I was called to see Master Anthony V., aged eleven, blue eyes, light hair, lymphathic temperament and scrofulous habit, suffering from necrosis of the femur of the left leg, at about the junction of the upper and middle thirds.

The previous history of the case is about as follows: Some three years before, while heated from coasting, his playmates had ducked him into a snowbank.

From this a severe cold was contracted, with high fever and inflammatory symptoms. He was seized with severe pains in the left hip, and was soon confined to his cot with periostitis of the upper extremity of the left femur.

During the succeeding years his suffering was great indeed.

The scarifier, the lancet and other heroic measures of the heroic school were used, till his thigh was well covered with the marks of his torture.

When I was called to see him he was very spare, and suffering from daily exacerbations of fever. The fistulæ were discharging profusely, and the outlook for my little patient was not encouraging.

At the junction of the upper and middle thirds of the left thigh, two openings, one on the anterior and the other on the internal aspect communicated with necrosed bone. Water injected into one opening returned by the other. The probe inserted into either fistula took an upward course, and readily impinged upon the necrosed surface of bone. By its use a considerable surface of roughened bone was determined and verified several times in the presence of other physicians.

After discussion, the acid treatment was determined upon, the two canals offering an excellent opportunity to use it to advantage and to test its merits.

The use of *Hepar sul.* 3, for a few days, allayed the fever. He was then given *Silicea* internally, and twenty-five drops of *C. P. sulphuric acid* in a cup of water was injected through a small tube into one fistula and discharged from the other. This was repeated three times a day. In a very few weeks considerable improvement was observed. The probe revealed a smoother surface over the necrosed area. Improvement continued, and at the end of six months he was before the Iowa State Homœopathic Medical Association, where he was very carefully examined. At that examination no diseased bone could be found. A few weeks later the fistulæ were allowed to close.

Twice only since the wound healed has the limb given him any pain, and then after severe exposure, the pain being of a rheumatic character.

Between two and one-half and three years have elapsed since the cure was effected. The affected limb is some two inches shorter than its fellow, the shortening being entirely limited to the diseased femur. So far there has been no tendency to recur, and the cure I believe is permanent.

## Hospital Notes.

### ORTHOPEDIC CLINIC.

BY PROF. SHEARS.

**CONGENITAL CLEFT OF THE HARD AND SOFT PALATE.**—Mary D., *æt.* sixteen years, congenital cleft of the soft palate and of the hard palate to the alveolar ridge. The cleft was unusually wide, the palate moderately arched, and the soft palate something less than normal in length; speech was almost unintelligible, and the patient suffered much from food becoming lodged in the nasal cavity and from nasal mucus dropping into the mouth.

It was decided to attempt the closure of both the hard and soft palate at the same time, making what is known as the Warren Langenbeck periosteal operation. The patient was given an anæsthetic, and the Whitehead mouth gag introduced. Grasping the uvula, a long, narrow, sharp-pointed, double-edged knife was passed through the uvula, and a narrow strip of mucous membrane removed from the margin of the cleft. The end of the uvula was freshened by the curved, sharp-pointed scissors. A small incision was now made about the middle of the hard palate, close to the teeth and down to the palate bone. A blunt, curved, periosteal elevator was introduced through the opening, and the periosteum and mucous membrane lifted from the palate bone over its entire extent, from the posterior attachment to the incisors in front. With curved, blunt-pointed scissors the soft palate was then detached from the bone of the hard palate, one blade being passed beneath the muco-periosteum and the other above the soft palate. As the tissues could not be brought together an incision was made close to the teeth, from the attachment of the soft palate to the incisor teeth in front. This left a muco-periosteal flap attached anteriorly and posteriorly, being continuous with the soft palate. The two flaps were now slid over the

cleft in the hard palate and united by silver wire and silk sutures. The tension on the soft palate being great a puncture by the double-edged knife was made, as recommended by Dieffenbach, thus relieving the strain and at the same time dividing the levators of the palate.

The patient was put upon a nourishing liquid diet, and talking forbidden. The silk sutures were removed in six days, the silver wire in ten. Union was complete except a small space at the juncture of the hard and soft palate, which was closed by a subsequent operation. The hard palate is now almost perfect in appearance, the soft palate a little short of normal length. The improvement in speech is quite pronounced, from being almost unintelligible she speaks quite plainly, but still with a nasal intonation. The intonation is much under control, and by making an effort and talking slowly is much improved. The patient has been furnished with a list of words in which nasal and mute consonants are found, upon which she practices daily.

Let me now refer briefly to some of the points which are the subject of controversy.

1. *The advisability of an operation.*—The seriousness and difficultness of the operation, with the many failures of union and speech, have led some surgeons to declare against the operation and advise the use of a rubber obturator. That some cases can be relieved and improved in speech by the use of the obturator is true, but that others cannot, is equally true. The cases that are benefitted by the obturator are the cases that show the most improvement after operation, and the cases that fail in improvement by the use of the obturator, are the cases that operation as a rule do not improve in speech. When one considers the great difficulty in finding any one who can make such an apparatus, the expense connected with frequent renewals, due to the changes in the form of the mouth from growth, and the rapid wearing out of the soft rubber, and above all the inconvenience of wearing such an apparatus, the desirability of the operation seems to me apparent. Even if there is no hope of improvement of speech, the great comfort which the closure of the cleft gives

to the patient in eating, and the barrier which it offers to the nasal mucus, are sufficient to make it the duty of the surgeon to attempt to remedy the defect.

2. *The use of an anæsthetic.*—Certain surgeons, fearing the dangers which may arise from the blood and mucus in the throat during profound anæsthesia, advise that neither chloroform or ether be used, but that injections of morphine or topical applications of cocaine be made. I have operated with and without an anæsthetic, and am firmly convinced of the advisability of using chloroform. If properly administered, and care be taken to keep the blood out of the throat, there is little danger. The greater control you have of your patient, and the care that you are enabled to exercise in the details of the operation, more than compensates for the additional risk.

3. *The method of separating the muco-periosteum.* Warren used sharp knives bent at an angle, and worked from the cleft to the alveolus. Langenbeck used a blunt rasp, and worked from the alveolus toward the cleft. I have tried both plans, and now uniformly practice the latter, because it is more easy of execution, more liable to raise the periosteum and less liable to injure the flap or produce hemorrhage.

4. *Sutures and their introduction.*—Silver, silk and silk-worm gut have each their earnest advocates. I usually employ silver wire for the hard palate and silk for the soft palate, but have seen equally good results when silk alone was used. It is comparatively easy of introduction, causes little inconvenience, is readily removed, and, so far as I am able to determine, equally effective. With silver wire and silk-worm gut the Goodwille tubular needle may be employed; with silk a long handled, curved needle is all that is needed.

Whatever the method of operating adopted, and however successful the operative result, very great immediate improvement in speaking must not be anticipated. Vicious habits of speaking have been acquired, and it will take time and education to overcome them, even with perfect organs.

## Book Reviews.

**PATHOGENETIC AND CLINICAL REPERTORY OF THE MOST PROMINENT SYMPTOMS OF THE HEAD, WITH THEIR CONCOMITANTS AND CONDITIONS**—by C. NEIDHARD, M. D., formerly Professor of Clinical Medicine, etc., F. E. Boericke, Hahnemann Publishing House, Philadelphia; 1898. 8 vo., cloth, pp. 188.

Clinical experience resembles Christian experience. Our faith in the record of either or both turns upon a sort of personal equation, and somebody must know and certify that the witness is capable, responsible, honest and truthful, or it can not be depended upon.

The title of this book is not a misnomer. Its contents are partly pathogenetic and partly clinical; but its value is mostly in the latter. The text is so arranged that the symptoms which have been verified by the author's experience are printed in conspicuous, black-letter type. This gives it the stamp of his strong individuality, and to those who have had the good fortune to know him personally and professionally, as well as to all others, will add immensely to the value of the work.

**THE HOMOEOPATHIC THERAPEUTICS OF RHEUMATISM AND KINDRED DISEASES**—by D. C. PERKINS, M. D. F. E. Boericke, Philadelphia; 1898. 8 vo., cloth, pp. 180.

This monograph furnishes a careful and conscientious study of its subject from a symptomatic standpoint. Whatever indications can be drawn from the pathogenetic records are placed under the proper rubric. Only 105 separate remedies are mentioned! The key-notes, or guiding symptoms, are printed in small capitals; those which are in a less degree characteristic, are in heavy type, and the rest, while supposed to be useful, are not emphasized.

“The question of dose, potency or dilution, is approached with hesitation. In the author's experience the middle and higher potencies have given the most satisfactory results.  
\* \* \* \* \* It is earnestly hoped that no case which the lower potencies fails to cure, will be abandoned until the higher have been faithfully tried. In the absence of rules or precedents, the young physician is frequently at a loss to

know how often the remedy should be repeated. The author is not prepared to lay down rules to be implicitly followed. His own practice, in acute and painful cases, is to repeat the remedy every three to six hours; in cases of a less severe nature, once or twice in twenty-four hours; in those of a chronic character every second or third day. It is always safe to instruct the patient not to repeat the dose during the progress of improvement."

Considering that rheumatism is almost as great an outlaw as hysteria, there is abundant justification for the study of its therapeutics from the point of view taken by our author. For while, in many cases, the "red flannel and six weeks" of old Dr. Warren might have as much effect to shorten the attack as our remedies do to wind it off and to cure it, there is a great advantage for the latter in averting and aborting its complications and its sequelæ.

We cannot place the book for reference reading until we have protested, in the name of our Western readers especially, against the barbarous clipping of the text by the elision of the definite article. Will the publisher see to it that, in future, his books, whether large or small, are not printed in this niggardly, bob-tailed English?

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#### EDITORIAL HONORS, ETC.

(We take the liberty to copy the following tribute to our colleague from the *Los Angeles World*, of California, for April 21, 1888. E. S. B.)

#### THE HOMŒOPATHIC PHYSICIANS AND PROF. LUDLAM.

Brief mention was made on Thursday of last week by some of the city papers of an affair of considerable interest to the homœopathic fraternity here. The point is deemed of such importance as to warrant something more than the passing notice it received. When Prof. Ludlam came from Chicago, for the purpose, it was learned, of performing some major operation in gynæcological surgery at Santa Ana, it was unanimously decided that one so widely known and honored should not leave the "City of the Angels" without feeling



the sense in which he is regarded by all the disciples of Hahnemann engaged in practice here. Before his arrival here as the guest of Dr. Fellows, a meeting was called at which arrangements were made for a banquet in his honor.

Accordingly, on the evening of Tuesday, the 10th, a large number, representing a majority of the thirty homœopathic physicians of the city, accompanied by their ladies, assembled at the Westminster Hotel, fully equipped with a program of entertainment for the evening. On entering the reception room, Prof. Ludlam was introduced to the assembly in a short and fitting speech by Dr. Fellows, which was responded to in a happy manner by the guest of the evening. The company then filed into the large and tasty dining room and sat down to a banquet, which, in itself, was sufficient to call forth the conventional flow of soul. After being satisfied with the exquisite viands the toasts came in order.

The toast, "Homœopathy of the Past," was responded to by Dr. Shorb. He gave a very interesting account of the struggles and triumphs of the early physicians when the city numbered only 5,000 inhabitants, a small proportion of whom were Americans; when "plug" hats were unpopular, and style of any kind was a sure mark of disfavor. One would think, while listening to the doctor, that he must have had a prophetic insight into the future of our city, and saw far away the time when the "boomer" should come to make glad the waste places. Certain it is that he has earned the title of the oldest practitioner of the new school now in Los Angeles.

The complimentary toast, "Homœopathy of the Present," was elegantly handled by Dr. Lummis. She showed how the little germ mentioned by Dr. Shorb had grown into a great tree, until now its branches reach out in a way that is fully commensurate with our material and populous increase. From a small and obscure beginning it has passed from the adobe period to the time when it does more than its share of "ringing silver door-bells."

Dr. De Cailhol, being credited as an especial admirer of the fair sex, was honored with the toast, "The Ladies," and after listening to his complimentary speech, the ladies pres-

ent must have been fully convinced that they had a very warm eulogizer, for they greeted him with hearty applause.

Dr. Ludlam then rose to make the regular speech of the evening. He commenced by saying that previous to coming to Southern California he had heard much both *pro* and *con* concerning it, but by personal inspection and comparison made from extensive travel in other parts, he was fully convinced that this was the genuine land of promise, the home of the invalid and the pleasure-seeker, and he had no doubt of its future being greater than he could now dream of. Referring facetiously to the productiveness of the soil, he said he fully expected to see even the telegraph poles break out into blossoms! He was especially pleased to see the progress of homœopathy here, and predicted its still greater spread. "Don't start a medical college here," said he, "because there are enough of such institutions now in the land; but keep up your clinical societies and learn the virtues of social contact, as this was the best means of breaking down prejudice, helping each other and your patients as well." It gave him great satisfaction to see so many of his former pupils in this far-away land, and to know that they were striving to maintain excellence in their calling. He felt, he said, as if he belonged to that much abused class, the tramps, for this was the *fourteenth* State to which he had been called for the purpose of operating in gynæcological surgery. He closed by making a comparison of the beginnings of homœopathy in Chicago and Los Angeles, and declared his belief that we had little to contend with here when he recalled the struggles of the new school in the Lake City.

The professor was so much pleased with California that he has determined to make us another visit, and when that time comes we have no doubt he will be as warmly received as at his first visit. \* \* \* \* \*

Following this came short speeches by Drs. Manning, Clark and J. W. Reynolds, and by Rev. Dr. Weller, all of this city. At midnight the company separated, all seemingly well pleased with the entertainment.

## Miscellaneous Items.

The Western Academy meets in this city May 29-31, and not in Minneapolis, as has been stated in some of the journals.—Dr. A. J. Howe has been elected an alderman of Santa Ana, Cal., and Dr. Breyfogle mayor of San Jose, Cal.—Mrs. Anna B. Greenleaf, sister of the late Dr. H. B. Gram, of New York, died April 23, at the age of eighty-six years and ten months.—We are pained to notice the death of Mrs. Frances A., wife of our old friend, Dr. J. W. Dowling, of New York.—The medical profession has lost another large-hearted and liberal member in the person of Prof. E. S. Dunster, of the Michigan University.—Dr. W. M. W. Davison has removed his office to 565 W. Madison St., city.—The marriage of Dr. Geo. Neuman Seidlitz to Miss Hess, of Iowa City, is announced.—Dr. Anna C. Hardy has located at Oak Park, Ill.; Dr. E. E. K. Chapman at Defiance, Ohio, and Dr. H. S. Patterson at Toledo, Iowa.—The Announcement and Catalogue of the "Old Hahnemann" will be out earlier than usual this year.—The veteran, Dr. D. S. Smith is making a tour among the State societies.—Prof. Ludlam made three laparotomies—one for fibroid and two for the removal of ovarian tumors—during his visit to California, and the three patients recovered promptly.—Prof. Bailey's paper, presented to the Wisconsin Society, on "The Climacteric," attracted merited attention.—The clinics at the Hahnemann Hospital, for the summer months, are most of them full and interesting.—The managers of THE CLINIQUE, as well as its readers, are mortified with its tardiness of late, and mean to remedy it as soon as possible.—It is rumored, but not certain, that Prof. Vilas will spend the summer in Europe.—Prof. Shears has been appointed Secretary of the Board of Trustees of the old College and Hospital.—The Forty-first Session of the American Institute of Homœopathy, celebrating its 44th anniversary, will be held at the International Hotel, Niagara Falls, June 25-29, and there are a thousand good reasons why all our readers should be there.—In accordance with the fitness of things, the Bureau of Diseases of Children, Dr. W. E. Reed, Chairman, will report at the meeting of the Clinical Society, June 2.

# THE CLINIQUE.

Vol. IX.]

CHICAGO, JUNE 15, 1888.

[No. 6.

## Original Lectures.

### MYXŒDEMA.

FROM A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL, OF CHICAGO, BY PROF. H. B. FELLOWS, CLINICAL PROFESSOR OF NERVOUS AND MENTAL DISEASES.

*Case 15237.—Myxœdema.*—Herbert W., age eighteen, came into the neurological clinic of the Hahnemann Hospital, March 26, 1888. His family are all healthy, except himself, and all well developed, and rather above than under medium height, muscular and spare. He is decidedly dwarfish. His height has not increased much, his brother says, since he was twelve years old. Up to that time he was a very active boy, both physically and mentally, but about that time a change came over him in both respects; he lost his ambition for active sports and became more torpid mentally. Since that time he has been more and more disposed to avoid all active exertion either of mind or body. Now he sits around quietly, not seeking any exercise unless urged to move by others. His muscular strength is sufficient when he chooses to put it forth. Mentally he is as torpid as physically, and although he answers intelligently when spoken to, he seems to take but little interest in conversation without his attention is especially aroused.

His face has a swollen, heavy appearance. The lips are very much thickened, and the alæ of the nose puffed out so that the lower part of the face resembles that of an

African. In the triangles of the neck the puffiness is so great as to resemble cushions. Whenever this swelling occurs it looks like an œdematous condition of the parts, but it does not show the slightest disposition to pit or pressure. The hands are very short, stubbed, "spade-like." The skin presents a rough, dry, scaly condition. The complexion is sallow, and yet, on closer inspection, shows something of a wax-like look, with a faint redness sharply bounded under the eyes. To the touch all the tissues are flabby.

The urine at times appears natural, at times darker than usual. It is free from albumen when it is normal in appearance. At times, however, it becomes very red, and then, as shown by a microscopical examination by Dr. Chislet, contains red blood corpuscles. No casts could be found in it at any time. These attacks of hæmaturia are periodical, but irregular.

The pulse is weak, but regular. An examination in the clinic for physical diagnosis, by Prof. Arnulphy, shows the muscular element of the heart sound to be poor; otherwise the heart sounds are normal; lungs in good condition; the vesicular murmur perfect; liver small; spleen larger than normal.

An examination in the surgical clinic, by Prof. Hall, reveals hæmorrhoids.

The first symptom noticed by the friends at the beginning of the case was constipation. This condition has been persistent. At times the breath is very offensive; appetite fair; sleep good.

The thyroid gland does not seem much different from natural, but, if anything, may be somewhat enlarged. The connective tissue in this region is so puffy that it is impossible to tell the exact condition of the gland. *Ars. 3x* was given.

This case is of especial interest as appearing in a boy at the early age of twelve years. It has been slow in its progress, slower than in general, but nothing so far tried in the way of treatment—and many doctors and some old ladies have prescribed for it—has stayed its progressive character.

This is the general history of these cases. Their general average of duration is reported to be about six years.

We append the following report made to the Clinical Society of London, England, May 28, 1888. This committee has had this disease under investigation for about four years, and their conclusions must, therefore, carry great weight with them:

(W. H. Broadbent, M. D., F. R. C. P., president in the chair.)

*Conclusions of the Myxœdema Committee.*—Dr. Ord, as the chairman of the Myxœdema Committee, read the following conclusions. He admitted that the time taken up in the investigation was protracted, but he claimed that when the results were known the time would not appear out of proportion. 1. That myxœdema is a well defined disease. 2. That the disease affects women much more frequently than men, and that the subjects are, for the most part, of middle age. 3. That clinical and pathological observations respectively indicate, in a decisive way, that the one condition, common to all cases, is destructive change of the thyroid gland. 4. That the most common form of destructive change of the thyroid gland consists in the substitution of a delicate fibrous tissue for the proper glandular structure. 5. That interstitial development of fibrous tissue is also observed very frequently in the skin, and with much less frequency in the viscera, the appearances presented by this tissue being suggestive of an irritative or inflammatory process. 6. That pathological observation, while showing cause for the changes in the skin during life, for the falling off of the hair and the loss of the teeth, for the increased bulk of the body as due to the excess of subcutaneous fat, affords no explanation of the affections of speech, movement, sensation, consciousness and intellect, which form a large part of the symptoms of the disease. 7. That chemical examination of the comparatively few available cases fails to show the general existence of an excess of mucin in the tissues adequately corresponding to the amount recorded in the first observations, but that this discrepancy may be in part attributed to the fact that tumefaction of the integ-

uments, although generally characteristic of myxœdema, varies considerably throughout the course of the disease, and often disappears shortly before death. 8. That in experiments made upon animals, particularly on monkeys, symptoms resembling, in a very close and remarkable way, those of myxœdema have followed complete removal of the thyroid gland, performed under antiseptic precautions, and with, as far as could be ascertained, no injury to the adjacent nerves, or to the trachea. 9. That, in such experimental cases, a large excess of mucin has been found to be present in the skin, fibrous tissues, blood, and salivary glands; in particular the parotid gland, normally containing no mucin, has presented that substance in quantities corresponding to what would be ordinarily found in the submaxillary gland. 10. That the full analysis of the results of the removal of the thyroid gland in man demonstrates, in an important proportion of the cases, the fact of the subsequent development of symptoms exactly corresponding with those of myxœdema. 11. That, in no inconsiderable number of cases, the operation has not been followed by such symptoms, the apparent immunity being in many cases probably due to the presence and subsequent development of accessory thyroid glands, or to accidentally incomplete removal, or to insufficiently long observation of the patients after operation. 12. That whereas injury to the trachea, atrophy of the trachea, injury of the recurrent laryngeal nerves, injury of the cervical sympathetic, and endemic influences have been, by various observers, supposed to be the true causes of experimental or of operative myxœdema (*cachexia strumipriva*), there is, in the first place, no evidence to show that, of the numerous and various surgical operations performed on the neck and throat, involving various organs and tissues, none, save those in which the thyroid gland has been removed, have been followed by the symptoms under consideration; that in many of the operations on men, and in most, if not all, of the experimental operations done by Prof. Horsley on monkeys and other animals, the procedure avoided all injury of surrounding parts, and was perfectly aseptic; that myxœdema has followed the removal of the thyroid gland in

persons neither living in, nor having lived in, localities the seat of endemic cretinism; that, therefore, the positive evidence on this point outweighs vastly the negative, and that it appears strongly proved that myxœdema is frequently produced by the removal, as well as by the pathological destruction, of the thyroid gland. 13. That whereas, according to clause 2, in myxœdema women are much more numerous affected than men, in the operative form of myxœdema no important difference of the same kind is observed. 14. That a general review of symptoms and pathology leads to the belief that the disease described under the name of myxœdema, as observed in adults, is practically the same disease as that named sporadic cretinism, when affecting children; that myxœdema is probably identical with cachexia strumipriva; and that a very close affinity exists between myxœdema and endemic cretinism. 15. That while these several conditions appear, in the main, to depend on, or to be associated with, destruction or loss of the function of the thyroid gland, the ultimate cause of such destruction or loss is at present not evident. The President congratulated the society on the completion of this important investigation, and said their thanks were due to the committee for the enormous work and the zeal and ability which had enabled them to present this summary of the report, and practically the report itself, during the present session. When they heard the conclusions, and imagined the enormous amount of investigation and research and inquiry which was embodied therein, four years seemed a comparatively short period for the completion of such a labor. The report would make the present session memorable. It reflected the greatest possible credit upon the society. It was the most important work yet carried out in its name. Already the labors of the committee had served to stimulate the carrying out of similar investigations in Germany, where men had been first convinced of the reality of the disease from the labors of the society and its committee. He thought the members could hardly thank sufficiently the authors of the report, in which it appeared that the only person not heard of was Dr. Ord, the chairman and director of the investigation. His name, nevertheless, would for all time be associated with the literature of the disease.



HÄHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.—  
Examination in Theory and Practice, and Medical Jurisprudence, February 7, 1888, by Profs. H. B. Fellows, M. D., and Chas. E. Laning, M. D.:

1. Give the diagnosis between measles and scarlet fever.
2. What are the essential and characteristic lesions of typhoid fever?
3. Give the diagnostic points and lesion in acute anterior polio-myelitis.
4. What are the symptoms and treatment of an attack of pleurisy?
5. What are the most marked symptoms of a cerebral hemorrhage into the region of the Corpus Striatum?
6. What are the symptoms and nature of *petit mal*?
7. What are the characteristics and significance of bronchial respiration?
8. What are the main physical signs of incipient phthisis?
9. What are the points of physical diagnosis between pleuritic effusion and pneumonic hepatization by (1) inspection, (2) palpation, (3) percussion, and (4) auscultation?
10. What is the most frequent sequela following scarlet fever?
11. Give the differential diagnosis between acute diffuse nephritis and chronic parenchymatous nephritis, and also between the latter in its secondary stage and chronic interstitial nephritis.
12. Name the symptoms of typhlitis and paratyphlitis, and mention some of their most frequent complications.
13. Give the differential diagnosis between gastralgia and round perforating ulcer of the stomach.
14. Give the chief diagnostic symptoms of lithæmia and name some of the most frequently indicated remedies in that disease.
15. Name the symptoms of acute and chronic colitis.
16. Give the diagnostic symptoms of cancer of the rectum.
17. Give the symptoms of atonic dyspepsia.
18. In the States where the common law holds, are communications from the patient to the physicians privileged by the courts?
19. Under what conditions can a physician be held for manslaughter when the patient dies?
20. What are the positive signs of death before putrefaction becomes evident in the body?

## Clinical Society Transactions.

JOSEPH P. COBB, M. D., SECRETARY.

The Regular monthly session of the Clinical Society convened at 8:30 P. M., June 2, at the Grand Pacific Hotel. The meeting was called to order by the second vice-president, Dr. J. D. Craig. Thirty-eight members were present.

Dr. Mary H. Landreth was proposed for membership by Dr. J. P. Cobb, and Drs. Lucy Waite and Kate Hickox were elected to membership. The treasurer reported the Society in a sound financial condition, with a balance in the treasury.

The election of officers (which was postponed from the May meeting) was held with the following result:

To fill the office of *President*, Dr. G. A. Hall; *Vice-Presidents*, 1st, Dr. W. S. Gee; 2d, Dr. W. M. W. Davison; 3d, Dr. E. E. Gwynne; *Secretary*, Dr. Joseph P. Cobb; *Treasurer*, Dr. R. C. Bain; *Executive Committee*, Drs. T. S. Hoyne, W. H. Burt, George F. Shears, J. E. Gilman and N. C. Kemp; *Board of Censors*, Drs. D. S. Smith, C. H. Vilas, R. Ludlam, Jr., W. E. Reed and B. S. Arnulphy.

### THE REPORT OF THE BUREAU OF THE DISEASES OF CHILDREN.

DR. W. E. REED, CHAIRMAN.

Dr. Reed presented a very interesting clinical report upon *Hemophilia*. [We very much regret that the copy of this paper could not be obtained for publication. The following notes of the discussion have been preserved. ED.]

*Discussion.*—On hemophilia. Dr. Laning said:

The Professor opened the treatment of this case with *Nuxvomica*, but gave us no special indications for his selection. The hemorrhage was principally from the bowels. In pre-

scribing *Carbo veg.* he seems to have been influenced to its choice by a single symptom. *Arnica* would appear to have been a well indicated remedy, owing to the venous character of the hemorrhage. As Dr. Reed mentioned, however, *Crotalus horridus* is certainly the nearest simillimum to the case. The point the Doctor makes with reference to heredity through the mother is interesting; for, no doubt, the tendency to this affection may have been so transmitted.

I have seen two cases, one a girl, eleven or twelve years old, who died from it. In that case the bleeding was mainly from the gums: Phosphorus gave temporary relief, and we had a verification of the symptom "small wounds bleed freely." A mere pin-scratch bled for hours in spite of our efforts to check it.

DR. REED—My prescription of *Nux vomica* was made in the evening, after an imperfect examination, and after the previous use of drastic medicines.

DR. J. D. CRAIG—Dr. Hempel once related to me the case of a boy who was much like the one described in the paper. He prescribed *Phos. acid* in drop doses, which resulted in a perfect cure without any return of the hemorrhage.

DR. G. F. SHEARS—I recall the case of a girl of the hemorrhagic disposition. She suffered from frequent and prolonged attacks of nose-bleed. She was brought to me to stop a prolonged oozing of blood from the gum following the extraction of a tooth. I noticed that wherever the child had been seized to lift her up spots of ecchymosis had appeared. She died after vomiting large quantities of blood.

DR. W. S. GEE—The report is certainly of great interest to us, for we are likely to meet these cases, and they are rather unsatisfactory in the results obtained. The remedy which ran in my mind as the symptoms were given was *Crotalus hor.*, and it is a little surprising that it was not given as it, no doubt, entered into the study of the case.

The common symptoms and the special ones including the jaundiced appearance, which may be due to liver complica-

tions or blood changes, also call for this remedy. It is found to be indicated very frequently for diseases and complications peculiar to warm climates.

In one case which presented at the hospital in 1881 *Baptisia* was the curative remedy. This remedy is used largely by the eclectics for this class of difficulties and certainly shows some homoeopathicity to some cases.

Two years ago the case of a young lady was turned over to me after she had been treated by two of the prominent members of that school in this city.

She was twenty years of age and had a hemorrhagic tendency as had been shown in attacks of obstinate nose-bleed and hemorrhoids, as well as an alarming hemorrhage at the recurrence of the menstrual flow. Amenorrhœa existed when a profuse flow of blood issued from another part of the body—vicarious menstruation.

When I visited her she had been flowing for seven weeks, and had the appearance of a bloodless wax figure. She had received large quantities of ergot and iron, and the last prescription was "a pint a day of — wine." In this case there was the continuous flow of bright red blood, and other symptoms which, when closely matched in the remedy, called for *Ipecacuanha*. She took the third without effect, but as a closer study confirmed the selection the 200th was given in water. There was an effect in a short time, and she recovered slowly.

Last November she called at the office with her sister. She was unable to talk because of an accumulation of blood under each side of the tongue. The mucous membrane of the mouth was dark, and looked as though blood had been oozing through almost the whole surface. She had a recurrence of the epistaxis and the profuse menstrual flow. She received *Arsenicum*, but derived no effect of a positive character, and later received the same potency of *Ipecac.* with prompt relief, and there has been no recurrence of the difficulty. She now weighs forty pounds more than when I first saw her. Whether there will be some symptoms in the autumn to mark the periodicity, of course we cannot foresee.

We can not determine at present the cause of the disease as the pathological conditions found in one case are absent in others, and the degeneration of the coats of the blood vessels, and changes of the blood do not give us a satisfactory explanation. We do know, however, that the nervous system is greatly involved in all cases, and we are successful in the treatment only when we take into careful study the nervous disturbances, and, as we would expect the peculiarities of our friend to appear in an acceptable photograph, so should we reproduce the peculiarities of the patient in the selection of the appropriate remedy.

DR. CRAIG—A case which Dr. Laning has seen with me was of this same hemorrhagic character. A lady, who did not menstruate until sixteen years of age, afterward had frequent and profuse periods. At one time she had a tooth extracted during a menstrual period, and the bleeding from the gums lasted for hours, until she fainted, when a clot formed and checked the oozing. Later in life she had hemorrhage from the bowels and hemorrhoids. The hemorrhoids were removed by the Carbohc Acid treatment, and the hemorrhage checked for a year or so.

When the bleeding returned it was accompanied by pains in the limbs. Dr. Laning thought it an attack of sclerosis of the cord. She is now improving more than either of us anticipated.

DR. LANING—This varied experience simply goes to show that the same symptoms may arise from different pathological conditions. Dr. Gee's case was different from Dr. Craig's, pathologically, and both differed from Dr. Reed's. The cause lies further back, and is to be found, I believe, in the nervous system. The pathological cause of the symptoms was different in each case, and therefore each required a different remedy.

DR. REED—It would seem to me the most plausible theory that the cause was in the nervous system.

AN URTICARIAL ERUPTION.—Dr. W. P. MacCracken reported the following:

*Case.*—May 12,—Bert S., set eleven, had been running around as usual in the morning. He had eaten a pint of peanuts, came into the house about noon and, being hungry, got a piece of gingerbread and went out to play again. While going across a vacant lot he dropped the ginger bread, but picked it up again and ate it. The morning was cold and damp.

The rhus tox. grows very abundantly in the lots and woods.

Shortly after eating the gingerbread his eyes began to burn and itch, and he rubbed them, but as they continued to grow worse went home. I saw him at 12:45 P. M., when he presented the following appearance: The eyes were puffed, and swollen until they were almost closed, the nose was swollen so that he could not breathe through it; there was a profuse discharge of a clear fluid from both the eyes and nose; the face and ears were puffy and swollen, and of a dull red color. The mouth and throat were dry, the tongue clean. He complained of his lungs paining him; said he could not breathe for the pain. For a short time there was a wheezing sound during inspiration. The temperature was normal, the pulse 82, but irregular at times, when he said his heart was thumping. But what he most complained of was the intense itching of his body. On stripping him I found his body covered with white spots about the size of a grain of rice, slightly elevated, and the skin seemed to redden as soon as the air touched it. The eruption was in irregular spots, some of them being as large as one's hand, while others were smaller, but all were irregular, and so close together as to make it almost continuous.

This eruption was most profuse on the back and buttocks, and did not extend below the bends of the arms or legs. The feet were icy cold, and it was almost impossible to get them warm. The itching was aggravated so much by the exposure to the air that it was almost impossible to keep him from digging into his flesh with his nails, until I got some olive oil, with which he was anointed from his neck to his knees. This stopped the itching immediately. I ordered cloths wrung out of hot water and put over his eyes, to be changed as soon as they became cool. He complained of feeling chilly. The

hot water-bag was put to his feet and more clothes put on the the bed. I then gave *Byronia* 30 every two hours. As he was quite thirsty I ordered hot milk for him to drink, and he had a glass half full every forty-five minutes during the afternoon.

I saw him again at 5 P. M. The eruption had almost disappeared from the body. We could tell where it had been by hard red spots, which looked almost as if he had been pricked with a pin; the swelling in the eyes, nose and face was very much reduced, the breathing was easy, the skin hot and dry, he had slept a little, but was very restless. His temperature was 99°, and the pulse 100. *Ars.* 30 every three hours.

May 13.—He slept well all night, the swelling had gone, except a little on the ears and face. The eyes were sensitive to light and the face felt stiff. He would put his hand on his cheeks to see if he could move them; the bowels acted freely; the urine passed last night and this A. M., high colored, but normal in quantity; temperature, 99°; pulse, 88.

May 14.—Found the young man up and around the house as usual. He felt weak when he tried to walk, and his eyes hurt him if he read very long. What was the trouble?

*Discussion.*—DR. GEE—I should consider the case reported by Dr. MacCracken as one of urticaria resulting from indigestion. The course and termination as well as the manner of its inception, warrant this inference. The restlessness, relief from heat, and aggravation from cold point very strongly to *Rhus* as the remedy, and as the *Rhus ven.* has a special action on the skin, that variety would be best suited to this case. But the patient would recover probably from the one attack without treatment, still self-limited diseases are often cut short and the tendency to a recurrence removed by using the suited remedy.

Dr. Laning agreed with Dr. Gee that in the report of this case there was no evidence of rhus poisoning. The case was undoubtedly one of indigestion.

A CLINICAL STUDY OF VIOLA ODORATA.—BY DR. C. E. LANING.  
—I have but seldom seen this remedy mentioned in our literature, perhaps for the reason that it is not often indicated, nevertheless it is of considerable value at times, and should not be overlooked. Of the diseases of childhood, in which it is most frequently indicated, I will mention pertussis, measles, and worm affections, or an irritable state of the gastrointestinal canal simulating verminous troubles.

In adults it is not to be lost sight of in hysteria, resembling both *Ignatia* and *Pulsatilla*, being a cross between them, so to speak, and at times acting well when neither of these remedies avail, although both may apparently be more or less indicated.

It is to be studied in cardiac affections, accompanied by much palpitation, in dyspnoea, and at times oedematous swelling of the lower limbs, pointing to more than a functional derangement of the great central organ of the circulation. The oedematous condition referred to does not of necessity indicate a cardiac lesion, for the action of the drug upon the hepatic and renal circulation is such as might at times account for the oedema.

In enuresis nocturna I have found it to act most satisfactorily in a certain class of cases. Generally these patients have been thin, nervous children, who, partly from mal-nutrition, and partly as a result of over exertion during the day, are completely exhausted at night, are fretful and peevish as a consequence, and their sleep is uneasy. The urine voided during the night has a peculiar odor, not so strong as the benzoic acid, nitric acid, or iodine urine, but is of such a character as to indicate a derangement of the mucous coat of the bladder.

It would appear to resemble both the last named remedies and *Sepia* or *Calcarea carbonica* as regards its action on the vesical mucosa. Accompanying this symptom will usually be found, as a concomitant, great nervous exhaustion. The child, as a result of this, acts as is characteristic of certain forms of nervous debility, viz.: It runs and plays violently for a time, and then drops down almost anywhere, completely ex-



hausted. The fact is too frequently overlooked, that neurasthenia in its worst form is sometimes made manifest by an inordinate desire on the part of these patients to work or play or exert themselves to the uttermost in some one direction. These are often the worst cases, far worse than those who, through debility, desire to remain inactive, mentally and physically.

*Viola od.* belongs to the first class of cases, and *Phosphoric acid* and *Sepia* to the latter. The urine is said to have the odor of violets from poisoning by this drug, as well as by *Terebinth*, but I have never seen such a case.

In measles I have occasionally found this remedy useful, when the child was very restless and uneasy, and the eruption did not make its appearance at the proper time and in the proper manner. Repercussion of the eruption also calls for *Viola*, though not so often as for *Bryonia*, *Veratrum viride* or *Cantharis*; and when the eruption is faint and the face is flushed, with evidence of cerebral hyperæmia, similar to that of *Belladonna*, and the skin is dry and hot, as one would expect to find in an *Aconite* patient. One peculiarity in such cases is, that the palms of the hands are quite moist while the rest of the body is dry. This is not always the case, but I have observed it a few times, and in all cases calling for this remedy this condition is likely to occur. During the catarrhal stage of measles the expectoration is often profuse, especially in the case of children who can raise the mucus. In younger ones the same excessive secretion occurs, as shown by the frequent attacks of dyspnoea and suffocation, for as a rule the sputa is tough and stringy, resembling that of *Kali bich.* and *Hydrastis*. Sometimes it is lumpy and jelly-like, which shows an involvement of the larynx, particularly of the pouches of Morgagni. This latter symptom accounts for the aphonia which usually accompanies the catarrhal stage, and which sometimes lingers after the other symptoms have disappeared.

In pertussis this hoarseness is often quite prominent, the fits of coughing are violent, spasmodic and protracted, resembling those of *Coralium rubrum*.

When indicated in helminthiasis it suits children of a fair complexion, tearful and nervous temperament, especially those who are troubled with enuresis. For obvious reasons *Pulsatilla* is often prescribed instead of *Viola* for these symptoms. The *Viola* patient dislikes the cool air, is easily chilled, craves lean and fat meat in large quantities (*Nitric ac.* and *Nux vomica*). Like the teucrium patient, the little sufferer is annoyed with intolerable itching at the anus, particularly in the afternoon and evening. As regards the patient's disposition, *Viola* differs from *Cina* in being mild and tearful instead of irritable and ugly. Both have the anal pruritus, and the *Viola* patient bores and rubs at the nose as the *Cina* child does.

*Viola* causes, or at least cures, the "milky urine" which is generally considered to be indicative of worms, but which is not an unfailing sign of their presence in the *primæ viæ*. This kind of urine, which depends upon an excess of the urate of soda, is indicative of intestinal irritation and imperfect digestion. As a rule, those remedies which derange the digestive function in such a way as to produce the urate of soda in excess, cause more or less bloating of the abdomen, and to this rule *Viola* is no exception. In such cases the liver is always functionally involved, and one of the consequences of this derangement under *Viola* is an aphthous condition, with constipation, upward pressure upon the diaphragm and a resulting dyspnoea. This furnishes a leading indication for the remedy, and explains its action through the *vagus*.

Another clinical point concerns the efficacy of *Viola* in hysteria and phthisis. In young girls who at puberty develop hysterical symptoms, especially if the menstrual flow is delayed and irregular and they are of a tuberculous diathesis, the *Viola odorata* should not be overlooked. The patient complains of dyspnoea, from tightness of the chest, or from a feeling of a heavy weight upon the thorax, in which it resembles *Phosphorus*. It is also suited to tall, thin, light-haired, nervous people, who are predisposed to phthisis. *Sulphur* resembles it in a general way.

To resume; we should not forget the *Viola odorata* in enuresis nocturna, helminthiasis, pertussis convulsiva, rubeola, and, for the older patients, amenorrhœa and irregular menstruation when accompanied by frequent hysterical attacks in a tuberculous patient.

REST VERSUS MOTION AS A CURE FOR DYSENTERY.—(The following letter has been received from an esteemed correspondent, and should have been published long ago.—Ed.)

MR. EDITOR:—I observe (on page 350, CLINIQUE, Vol. VIII.) a gross misstatement of my theory and practice in *Lienteria* not *Diarrhœa* or *Dysentery*. In these latter, dysentery especially, I order the utmost quiet, not allowing the patient to rise from a recumbent posture, *even for a motion*. I enclose copy of my printed directions. Of uncomplicated idiopathic dysentery I have never lost a case since (forty years ago) I learned the pathology and practice of the disease in a fearful epidemic in Plaquemine Parish, La., where I went to study it. It was there I learned the use of proper *rest* and *position*, in addition to homœopathic medicine.

Dr. Craig's cases that were so much benefited by gentle *motion in carriage* were probably mainly *lienteria*, not *diarrhœa*, and the evacuations were more frequent at night and early morning. In that case even more active rolling would answer.

In dysentery my printed rules are as follows:

“Go to bed and stay there till you have a perfectly natural motion. Don't rise from a recumbent posture even for an evacuation. Use a bed-pan, or keep a towel, folded once, beneath you, on which spread three or four sheets of soft cartridge paper to receive the small mucous or bloody passages, which must be immediately carried out. Resist the desire to have a passage AS LONG AS POSSIBLE; lie always on the back or left side, never on the right side. Diet simple. Drink cool toast-water. Strictly obey these directions, and you will be convalescent in four days and nights.”

Please place me in proper position with the members, and greatly oblige

Your faithful

D. S. OLIPHANT, M. D., Toronto.

## Hospital Notes.

### THE WOMAN'S CLINIC.

#### SERVICE OF PROF. LUDLAM.

**PELVIC CELLULITIS AND THE MORPHINE HABIT.**—*Case 20207.*—This patient had been in our hospital two years before, and remained there nine weeks for the treatment of pelvic abscess. Its discharge took place through the rectum, as it had done twice before, and she left the hospital greatly relieved. The peculiarity of this third relapse was that, as the abscess developed in the left side of the pelvis, she suffered such atrocious pain of a neuralgic character that before her admission she had resorted to large doses of morphine for its relief, which habit she was obliged to continue until the pus had found vent. We cautioned her against the further use of the opiate after that period, and she had the pluck and the character to keep from it afterward, so that, in the two years past, there has been no return of the pelvic suffering in any form, and she has been quite well.

The clinical points show (1) the possibility of curing pelvic cellulitis, in some cases, by other than surgical means; (2) the occasional occurrence of neuralgia from mechanical pressure in the development of pelvic abscess; and (3) the importance of keeping such patients from drifting into the morphine habit, which, when it is fully formed, certainly increases the risk of relapsing abscess.

**MENSTRUAL BRONCHOCELE.**—*Case 20208.*—A young woman of twenty-three came for relief from a periodical headache, with "swelling of the throat," at every menstrual period. This swelling was referred to the region of the thyroid gland, was bilateral, most marked at the month, and almost entirely disappeared in the interval between the periods. It did not cause pain, but induced a sensation of choking, or of suffocation, as if something pressed upon the windpipe. With the headache

she had occasional, but not severe vertigo, and her vision was impaired by a strong light. When the neck was swollen the eyeballs had been noticed to protrude a little, but they afterward receded. Slight exertion caused considerable palpitation, which also was worse at the month.

This case was recognized as one of those which should be styled *menstrual*, and which are the counterpart of those cases of Graves' disease in which the peculiar hypertrophy of the thyroid gland recurs with each successive pregnancy, and then subsides or disappears. It is perhaps the only form of goitre that is curable by internal remedies. *Spongia*, 3d trituration, three times a day.

CLIMACTERIC HEADACHE.—Case 20209.—Women of a full apoplectic habit are very prone to suffer from headache at the menopause, and in this class of subjects, especially, we learn to be apprehensive of serious consequences, if such attacks are not soon relieved. The possibility of sanguineous effusion, with a resulting coma or paralysis, are always present with the careful physician when he prescribes for the relief of this form of headache in this class of patients.

Nothing can exceed the satisfaction and the confidence with which we direct them to take *Aconite* or *Belladonna* or *Gelsemium*, under the well-known indications. And the same remark applies to *Sanguinaria* and *Veratrum viride* in the pulmonary congestions that are incident to the same critical period.

A QUESTION OF PREGNANCY.—Case 20210.—Not many years ago Prof. Thomas invented a word signifying a dread of cancer—carcinophobia. I have often thought, said Prof. Ludlam, that there should be a word signifying a dread of pregnancy, for there are not many days in which the busy doctor does not see cases of this kind, and in which he is not called upon to decide a question that is quite as important as the recognition of a malignant disease. Here is a poor woman, with a babe of thirteen months in her arms. She nurses it, and has a plentiful supply of milk. She menstruated

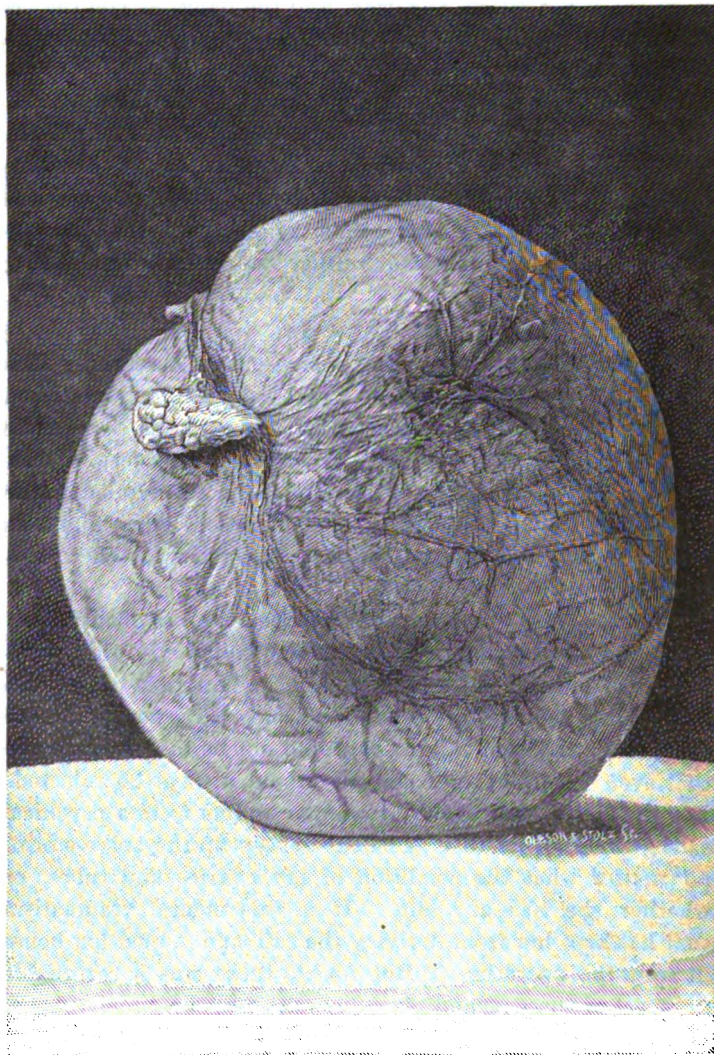
when it was eleven months old, but now is very anxious because she has "missed" the two intervening periods. There are no symptoms of pregnancy other than the arrest of the flow; she is not ill in any way, and the baby, as you see, is flourishing, but still she cannot help feeling worried lest she might have again conceived.

Of course we cannot say with certainty, at this early period, whether or not she is pregnant; but we can comfort her with the assurance that it is quite common for women who are nursing their babies to have their periods once or twice, and then to skip them for some time, after which they are resumed again in a normal way, either before or after weaning the child.

**HYSTERO-EPILEPSY AND THE BATTEY-TAIT OPERATION.**—This patient was one upon whom Prof. L. had performed an oöphorectomy with the removal of the diseased tube some months before. Although the lesion was a very serious one, necessitating extirpation, and although the woman had made a good but slow recovery from the operation, the relief was transient, and now the spasms have returned with their old-time severity.

The question of the value of this operation, or of any other, for the relief of pronounced neurotic symptoms is still *sub judice*. It must be settled by experience, and that experience will need to be carefully sifted. In such cases as this, where there is an apparent failure, it would not be fair to conclude that even so serious an expedient should always be rejected. For the fact is that this poor woman suffers from a psychical cause which, of itself, is sufficient to keep up the nerve-storm, no matter what the condition of her ovaries and tubes, or whether she has any left. It is this mental traumatism that has kept her from deriving the full and hoped-for benefit from the operation. But for it, there was a reasonable prospect of success, and, even yet, she may be greatly benefited as time runs on, for the full effect of this kind of surgical treatment is not always immediate and complete.

REMOVAL OF A PAROVARIAN CYST WEIGHING THIRTEEN POUNDS.  
—RECOVERY.—June 20 Prof. L. showed the class a rare specimen of a parovarian cyst which he had successfully removed



from a young unmarried woman four weeks before. The operation was made at the Chicago Gynecological Institute, and

the patient had recovered without a single troublesome symptom.

The peculiarities of this unilocular tumor are the remarkable thinness, the conjunctival blueness, transparency and vascularity of its cyst-wall; the opaline tint, and the limpid, spring-water character of its contained fluid, as shown in a bottle of it that had been preserved; and in the absence of peripheral and visceral adhesions. (See the cut.)

The cyst was quite independent of the corresponding ovary, which is plainly visible in the specimen, and must therefore have developed from the remains of the Wolffian body. This is the kind of ovarian tumor, falsely so called, which sometimes gets well spontaneously, either by rupture and absorption, or through puncture and tapping. The first fluid is bland and innocuous, and such cysts do not often refill. When they do, however, its character may be changed so as to become more noxious. But the serious argument for their removal, instead of their evacuation, is the risk that their lining membrane may degenerate into a papiloma of the malignant variety, and so cause them to assume a fatal form.

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## Book Reviews.

**MEDICAL AND SURGICAL LECTURES ON THE DISEASES OF WOMEN. A CLINICAL AND SYSTEMATIC TREATISE.** By R. Ludlam, M. D., Professor of the Medical and Surgical Diseases of Women in the Hahnemann Medical College and Hospital, of Chicago; late President of the American Institute of Homœopathy, etc., etc. Lectures delivered from 1870 to 1887. Sixth edition; revised, enlarged and illustrated; pp. 1093. Chicago: Halsey Bros.' 1888.

The announcement of a new edition of Prof. Ludlam's book has been received with no little interest by the profession at large, and although but three months have elapsed since its issue, half of the edition is already sold. We need not recapitulate the contents chapter by chapter. It is enough to say that they are clinical lectures delivered during the past seventeen years, and are faithful records of the gynecological work done at the Hahnemann Medical College and Hospital in Chicago. Each case is explained by a clinical lecture, and then follows a systematic essay upon the disease in all its phases, and the patient is prescribed for or treated surgically or specially as required.

The first seven lectures are systematic, embracing the seven critical periods in the life of woman, and the general pathology of the same, including parturition, puerperality, physical diagnosis in gynecology, chlorosis, amenorrhœa, dysmenorrhœa and menorrhagia. A large range of diseases, such as the practitioner is liable to meet with daily, are described, and throughout the work the author has introduced into this edition many illustrations—some of them entirely new.

Lectures 42 and 43, upon uterine cancer, will be found most excellent, well up to the most recent advances in science, and will repay the attention of the practitioner and student who carefully reads them.

Our author insists upon a correct diagnosis in cancer, and he says very sensibly:

“Do not forget, therefore, that, in this as in all forms of uterine and ovarian disease, where it is a question of tu-

mors, or bits of tissue, discharges or ulcerations that are cancerous in their character, it is much safer to depend upon what you will learn from careful clinical observation, than upon what you can detect with your microscope. For, invaluable as that instrument is in the diagnosis of renal or other disease, too much has certainly been claimed for it in the detection of malignant disease of the womb."

He adds that the educated "touch" is the best means for making a diagnosis of epithelial cancer. Every gynecologist will approve of this.

Ovaritis and hysteria follow, both being treated systematically and thoroughly. We now come to that portion of the book in which surgical procedures are described. There is an excellent chapter upon vesico-vaginal fistulæ, in which the operation is well described and illustrated, exhibiting the most recent instruments for the same.

Lecture 54 describes lacerations of the perineum, and the usual operations as practiced by the best authorities, such as Thomas and Emmet. Our author mentions Bantock's operation, applicable when the rent extends up the rectum, and illustrates it by two cuts that are very practical, exhibiting a method very excellent according to our own personal experience. Dr. Ludlam mentions Lawson Tait's operation for lacerated perineum—applicable especially when the rent extends up the rectum an inch or more.

This operation of Tait we regard as one of the triumphs of gynecological surgery, and our author, on p. 903, presents a remarkable instance of it upon which he operated in 1881. It was upon a woman *æt.* 55, and the rent extended up the recto-vaginal septum two inches, and had existed for thirty-three years. Lawson Tait's operation was made, and a perfect union was the result. At that operation I had the honor to be present, and was greatly interested and instructed thereby, and since then have tried Tait's method, usually with success. Why our author has not seen fit to carefully describe and illustrate the technique of this operation seems surprising.

The principle of this operation is also applicable and practical in the repair of a vesico-vaginal fistula, still our

author does not mention it under that head. Tait's operation is difficult to describe, but it is made by dividing the recto-vaginal septum, and so forming the flaps. (1.) No tissue is removed. (2.) The rent is so split that the mucous surfaces are turned into the rectum, and thus *reverted*, go to their original normal position, while the vivified surfaces are brought together and carefully adjusted. I will not give the whole technique, as it is difficult to describe, but the first time I ever saw the operation made it was by Prof. Ludlam, at his clinic in Chicago.

The technique of the operation for laceration of the cervix is most admirably illustrated, and he shows Skene's parrot-bill scissors, an instrument that materially assists in the easy performance of the operation. On p 901 a new needle is exhibited, viz.: Riverdin's perineal needle. I tried it some months since, from the recommendation of Prof. Ludlam, and find it a great improvement.

We now come to the new portion of the book, which contains something not in previous editions, viz.: Laparotomy, Ovariectomy, the Battey-Tait operation, etc. Dr. Ludlam's large experience as an ovariectomist is well known, and whatever comes from him upon these subjects may be accepted as authoritative.

Lecture 58 is upon Explorative methods of diagnosis or explorative diagnostical laparotomy.

This proceeding is to deliberately open the abdominal cavity by an explorative incision, for the purpose of making a precise diagnosis, and is an operation quite justifiable, and one that is now frequently performed. It is made for the relief of suppurative peritonitis, for gun-shot wounds of the abdomen and intestines, to remove the ball and to suture the intestinal wounds, also for strangulation of the intestines. This operation of laparotomy for wounds of the intestine has been made several times in St. Louis during the past year with success. On page 947 he introduces a cut which exhibits the lines for making the various incisions in this operation, and, in speaking of the operation, says:

"It completes the diagnosis, and literally opens the way

for relief in pelvic abscess, pelvic hæmatocele, puerperal peritonitis and cellulitis with sero-purulent accumulations, in all forms of salpingitis, and in case of cystic or sclerotic degeneration of the ovaries. It is essentially conservative, the same as the abdominal incision for gun-shot wounds of the intestines, or for the direct examination of the stomach, or of the gall-bladder. And not only will its careful employment with good surroundings result in the saving of human life in certain cases, which were supposed to be beyond relief before the daylight was let in upon them, but the specialist who makes these incisions with comparative frequency will thereby learn to recognize and to differentiate all sorts of abdominal tumors with a greater degree of aptness, precision and certainty. It ought to be added to the reasons given by Dr. Bantock in his "Plea for Early Ovariectomy."

Several clinical cases of explorative laparotomy are detailed that are of great interest, and on page 953, in speaking of the practical results, he says:

"My confidence in the value of the exploratory incision as a *dernier ressort* has been steadily increased, and when a woman is dying from an obscure abdominal disease the exploratory incision is not only admissible, but it is sometimes a necessary procedure," and this is the experience of the most advanced surgeons and gynecologists of the present date.

On the tapping of ovarian cysts, page 957, our author very properly speaks as follows:

"Simple as it is, old as it is, and often as it is made by the general practitioner, the operation of tapping through the abdominal wall is *not devoid of danger*. In the old days, when a dirty trocar and canula were often employed and antiseptics was unknown, the mortality from tapping was greater than it now is from the capital operation of ovariectomy."

We agree with our author about tapping, and think the explorative operation should not be made unless the practitioner is prepared to perform the operation for the complete removal of the tumor, if he finds positive evidence from the character of the fluid discharged that he has a case of ovarian dropsy to deal with.

Lecture 59, p. 960, treats of ovariectomy. He mentions the indications, and contra-indications, recommends an early operation, asepsis, antiseptics and cleanliness, and gives a

number of very interesting clinical cases, describes the technique of the operation, and gives illustrations of some of his instruments.

He says:

“The glamor that is thrown over this subject by the remarkable success of a few noted specialists may have tempted you to suppose it an easy matter to make such a reputation, if only you can find the patients, and they will consent that you shall operate.

“The truth is that the relative popularity and safety of ovariectomy since Dr. McDowell first made it in Kentucky, in December, 1809, is due to such a persistent experimentation, training and drill in everything that belongs to it, as has never been bestowed upon any other surgical operation. As a direct, although a somewhat tardy result, instead of being rejected as hazardous, unwarrantable and murderous, as it once was, ovariectomy is now made as successfully as any other capital operation. Indirectly its benefits are incalculable, for it has opened up the whole domain of abdominal surgery. Until it was practiced the peritoneal cavity, and all that it contains, was as inaccessible, surgically, as the chambers of the heart. But now there is not an organ that is covered with the peritoneum which cannot, if necessary, be safely reached by the knife of the skillful gynecologist; nor a scrap of tissue within its ample folds that is out of the range of his vision.”

In operating he does not discard antiseptics, like Tait and Bantock, but regards “a middle course the safer one”—insisting upon the most thorough cleanliness, and resorting at the same time to antiseptics, as they may be rationally needed. He mentions that, instead of evacuating the bladder before operating, he sometimes adopts Keith’s advice, “to leave it distended, in order that its outline may be more readily made out, to protect it from injury.” This is a good point and practical. He mentions the necessity of having no assistants who have been attending cases of contagious disease, or who have been exposed to the air of a dissecting room within some days preceding; this is also a very practical regulation.

Lecture 60 is upon the after-treatment in ovariectomy. This is a very sensible and practical lecture, quite up to the latest advances. He enumerates “peritonitis, tympanitis

and vomiting as the furies of abdominal surgery," and gives excellent advice for their prevention and treatment. Our author mentions the most recent treatment for peritonitis, following the operation of ovariectomy. He says: "even in the simplest cases it is best to prevent the bowels from being constipated," and when they are constipated, and signs of peritonitis are present, he advocates the giving of an active saline cathartic. The old way of relieving peritonitis by opium has passed away.

In September last an operation for ovariectomy was made in Connecticut, by an expert from New York City. He left the patient in charge of her physician, an old-time doctor, who, instead of giving the patient a saline cathartic to open the bowels for a peritoneal complication, gave opium, and the patient passed away. The physician who made the operation was quite confident that she would have recovered if his order to give a saline had been carried out.

Dr. L. advocates the proper use of the drainage-tube, the reopening of the wound for secondary hemorrhage, etc., mentions the possible sequelæ of parotitis, thrombosis, acute mania and bed-sores, all of which are important and instructive. On p. 1000 he speaks of the results of ovariectomy:

"Up to this date (December, 1887) there is not upon record a well authenticated, radical cure of a true ovarian cyst by any other than surgical means. When this statement is coupled with the fact that those who survive the risks of ovariectomy almost always recover their health to a degree that seldom follows in other very serious operations, we naturally inquire into the rate of its mortality. What proportion of all of those who are operated upon for the removal of these tumors outlive the immediate danger and regain their former health?"

Our author mentions electricity for the treatment of fibroids, but says that he has had no personal experience in its use. This treatment as advocated by Apostoli, of Paris, known as electrolytic, or electrolysis, is really a galvano-chemical cauterization, and from our own little experience, is well worthy of trial, and seems to be the "coming means" in gynecological therapeutics. It has been adopted by no less an authority than Keith of Edinburgh, who says, "he would

consider himself guilty of a criminal act, were he to advise any patient to run the risk of her life from an operation of hysterectomy without first trying Apostoli's method."

Lecture 62 describes diseases of the uterine appendages; he says, p. 1024:

"Before describing the different methods of operating I must caution you against perpetrating a scandal and a slander upon all reputable gynecologists by the use of the word 'spaying,' as applied to the removal of the ovaries and their appendages in women. The spaying of females among animals, as you very well know, is resorted to for the purpose of fattening them, and to prevent procreation, and for no other reason. No honorable gynecologist has ever proposed or practiced oophorectomy in women with these objects in view. It is a surgical resource that is always and invariably designed for the removal of diseased structures, which are directly and decidedly mischievous, and which, by involving and complicating the menstrual and nervous functions, give origin to chronic disease and invalidism. The indications for it may not always be very clear and definite, and it may sometimes lie within the domain of doubtful surgery, but, in decent hands, it never will deserve so unkind an epithet."\*

Our author well differentiates the cases where this operation may be justified. Recently Dr. Polk has advocated opening the abdominal cavity, and breaking up the adhesions of the Fallopian tubes, ovaries and uterus, and then closing the incision. He claims such an operation warrantable. Dr. L. has a good description of Tait's operation of salpingotomy for pyosalpinx, and hæmatosalpinx. These operations are warranted, and, in our own observation, have been frequently successful.

The book ends with a chapter upon fibroid tumors of the uterus, and uterine polypi.

This book has been written while engaged in the duties incident to a very large practice, and further comment upon

\*The word "spaying" is eminently objectionable, for it is entirely misleading. Whenever used it at once conjures up the idea of masculine voice, the growth of a beard and other male peculiarities, as well as the loss of sexual appetite, not one of which is an incident in the complete after history of a case of the removal of the diseased uterine appendages from a mature woman. It is a term, therefore, which ought not to be used, as well for the other reason, which you so trenchantly pointed out, that it is one of reproach to the poor sufferers who have had to submit to it. (Cor. of LAWSON TAIT.)

it is uncalled for. Altogether, this last edition thereof impresses us very favorably, and all who are fortunate enough to procure it will be amply repaid in its perusal. As a guide for the young practitioner it will be found useful, and we predict for this sixth edition a host of new friends.

The publishers, Messrs. Halsey Brothers, have issued the work in a good style, the paper is excellent, and the binding of half morocco is unexceptionable.

T. G. COMSTOCK.

**A PRACTICAL MANUAL OF GYNECOLOGY.** By G. R. Southwick, M. D., Assistant Professor of Obstetrics in the Boston University School of Medicine; L. M. Rotunda Hospitals, Dublin. Boston: Otis Clapp & Son. 1888.

In the preface of this book two reasons are assigned for the fact that the progress of gynecology has been in the direction of surgery rather than of medicine. They are "partly because we lack a thorough knowledge of the effects of drugs on the female organism, and partly because a surgical operation appears to be a more rapid and definite method of treatment." We would add another reason, which is that, until quite recently, many and most of those who have reported cures in this particular department, by internal remedies alone, did not have the training and the diagnostic ability that would have rendered their evidence valid. For gynecology is, indeed, as our author says, "a child of the present generation;" and so long as physicians were deprived of special clinical advantages, and of recourse to modern gynecological literature, their experience, like Dunham's report of a cure of ovarian dropsy with colocynth, must end with an interrogation point.

The early followers of Hahnemann did a good work, and are deserving of great praise for what they accomplished in curing the diseases of women in common with affections of all kinds; but, useful and skillful as they were, it was impossible for them to leave us a very valuable legacy in uterine therapeutics. When Jahr was forced to go to the materia medica for almost everything that was afterward contained in his book on the diseases of females, the product was almost worth-



less, for it had no clinical foundation. It bore the same relation to the symptom-codex that the chips do to the wood-pile, but, in so far as gynecology was concerned, that was about all there was of it. And so of Eggert's book with the nasty title, excepting that one was published before and the other after the "child" was born.

The fact that hitherto we have been trying to develop a special therapeutics before we had a special pathology should be remembered, not only with regard to what the general practitioner has contributed, and a few authors have gathered under the greatest possible disadvantages, but also in weighing the comparative value of the newer and later yield in this department. Dr. Southwick's book is seasonable, not only because the drift of the gynecologist is toward manual means when medical resources would often do better work, all things considered, but also because, with a better idea of special and peculiar forms of disease, we can test the value of our remedies more intelligently than ever before. His aim to place the indications for those remedies where they can be used in the light of modern diagnosis, and by physicians who are not quite satisfied with the scope of the symptom-hunter, is praiseworthy and acceptable. To follow the line of practice indicated will surely give us better results and more creditable statistics, bye and bye, than the old faith-cure method of decrying the help of a careful discrimination in etiology, diagnosis and prognosis.

One of the good points in the book is that there is frequent reference to the experience of others, and that, when a case is cited, the name of its author is invariably given. This is a just and honorable way of dealing, and one in which the reader is made aware of the degree of confidence that he may repose in the remedy that is advised. Another merit is that the remedies have a sign appended by which such as have often been given with good results, may be known from those which are seldom indicated.

The author has had the good sense in a manual of this kind not to attempt too much, but has limited his work to the minor surgery and surgical pathology, as well as to the simpler expedients of local and manual treatment of the diseases of women. This is no small merit when the tendency is to amplify and mystify the subject, and to multiply the volumes that are devoted to it, especially by the German writers of the present day. The proper emphasis is placed upon cleanliness, asepsis, the choice of instruments and all sorts of expedients with which one who does anything in this line of practice should be and must be familiar.

A special merit of this volume, which in our time should not be overlooked, is the excellent language in which the book is written. In this particular, among our younger gynecologists especially, the work is a model that is worthy of imitation. If the author will elide the commonplace talk on hygiene, deteriorated health of American women, etc. (as if there were no invalids, and no women's clinics anywhere else), relegate this matter to the beginners in social science, and fill the same space in future editions with clinical verifications by competent observers, he will increase the value of a very good book and place the whole brotherhood, and sisterhood too, under lasting obligation.

R. L.

A REPERTORY OF GONORRHEA, WITH THE CONCOMITANT SYMPTOMS OF THE GENITAL AND URINARY ORGANS. Arranged by Samuel A. Kimball, M. D. Otis Clapp & Son, publishers, Boston.

This book is exactly what it purports to be, and is an excellent arrangement of characteristic symptoms. One hundred and thirty-four remedies are discussed. The loyalty of the author to the homœopathic system of medicine as a means of *cure* is a strong argument why this book should be consulted as a guide to practice in this disease. In a word, the disposition of the disease made by the author is found in the following: "Any remedy in the materia medica may be required if indicated by the concomitant or constitutional symptoms. In fact the gonorrhœal discharge should be the last thing to base a prescription upon, as we should prescribe for the patient, not for a pathological lesion." The author also insists that suppression of the discharge is in no sense a cure, and the time for the homœopathic remedies to cure may be long, but that a cure—long lasting and positive—can and does come through the intelligent administration of a strictly homœopathic treatment.

The book has much of merit, and should be frequently used to be correctly appreciated.

E. S. B.

## Miscellaneous Items.

Prof. Hall has been elected president of the Clinical Society for the current year.—Prof. Crawford will resume his practice in Chicago.—Dr. E. M. P. Ludlam has removed his down town office to 70 State Street.—Walter Blaine, Esq., son of the distinguished senator, will deliver the next course on Medical Jurisprudence in the "Old Hahnemann."—Dr. B. C. Kelly (87) was married recently, and is located at Seneca, Kas.—Other newly located doctors are H. W. Brant, Packard's Mills, Ind.; Dell Dresser, Ogdensburg, N. Y.; George R. Smith, Dover, N. H., and Annis S. H. Gooding, Owosso, Mich.—Dr. W. A. Dunn, who is to give a clinical course on Diseases of the Throat and Nose in the Hahnemann next winter, is spending the summer on his specialty in the hospitals in Vienna.—Prof. Hoyne resumes the charge of the Skin and Venereal Clinic, and Prof. Leavitt will conduct the Children's Clinic.—Having also taken the degree of the Toronto University, Dr. Chris. Bollen has returned in good health and spirits to his home in Australia.—Sanitary workers will do well to read the excellent reprint on "Water," by Dr. Charles W. Moore, of San Francisco.—The *American Dermatologist*, a new publication on skin affections, for which there is a howling necessity, publishes a salutatory under the caption of "Prefatory Egotism."—THE CLINIQUE enjoyed the opportunity of a brief visit with a score or so of friendly doctors who were in town during the recent National Republican Convention.—Prof. Laning is ready for consultation in chronic and obscure cases, whether in town or country.—If this issue is too full of gynecology it is because everybody except the editor is too busy to write for it.—Our sympathies are with our old Denver friend, Dr. Emlen Lewis (72), whose excellent wife died April 19.—Dr. J. P. Cobb has been appointed to the chair of physiology, *vice* Dr. Harvey, resigned; and Dr. T. Eugene Jordan, adjunct to the chair of chemistry and toxicology in the Hahnemann Medical College of Chicago.—Prof. Gilman will read the next report before the Clinical Society.

# THE CLINIQUE.

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[No. 7.

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## Original Lectures.

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### ON THE THERAPEUTICAL VALUE OF CERTAIN DIAGNOSTIC SYMPTOMS.

BY C. E. LANING, M. D., ASSOCIATE PROFESSOR OF THE PRINCIPLES  
AND PRACTICE OF MEDICINE IN THE HAHNEMANN MEDICAL COL-  
LEGE AND HOSPITAL OF CHICAGO.

As a medical teacher, I have long insisted that no matter how much the physician may know regarding the physiological action of remedies, nor how extensive his acquaintance with the pathogenesis of our remedies, no matter, I say, how familiar he may be with all this, he is not prepared to, nor can he make a scientific prescription until he comprehends the significance of the various symptoms appearing in a given case. Many there are, no doubt, who will take strong exception to this assertion, and with apparently good reason. Some will insist that a remedy prescribed in accordance with the law of similars will *always* cure if a case be curable. If by "accordance with the law of similars" is meant the selection of a remedy corresponding to the "totality of the symptoms" then I assert that there are curable cases which cannot be helped in the least if only this means of selecting a remedy be pursued.

To the scientific physician the entire group of symptoms presented in any given case must include three things, viz. : (1) The location of the lesion or lesions, (2) the character of the pathological changes which have taken place at the seat of

the lesion, and (3) the remedy needed for the cure of the case.

In other words, some of the symptoms enable us to make a diagnosis, or to name or classify the disease, while yet others, as stated, including very often some which have assisted in the diagnosis, enable us to understand the nature of the morbid changes which gave rise to the entire group. Every physician knows that he may have made a diagnosis and arrived at satisfactory conclusions as to the pathological changes which have taken place, and yet needs to look further for some of the remaining symptoms of the case in order to select the proper remedy. Now if one does not know how to attach to these symptoms their proper value and significance, individually and collectively, he cannot, as I have stated, make a *scientific* prescription. He may prescribe a remedy which possibly will cure, but he has not done it upon such scientific principles as he would employ in working out an example in mathematics, or with such an understanding as to how he did it as would enable him to solve all similar problems in therapeutics. There are times when a certain number of the "totality" of symptoms presented in a case serve only to indicate the location of the lesion, and have no meaning at all so far as the selection of a remedy is concerned. If we attempt to use these indications in a curative way they will surely mislead us. We must guard against this practice, for it is a weak point in our therapeutics. Let me illustrate :

All cases of paralysis, loss of nerve power, are theoretically and in many instances practically preceded by a state or stage of irritation, during which the organs controlled by the nerve or nerves affected have their functions changed to a degree and in a manner which corresponds to the degree of continuance of the irritation. If, then, a nerve is under the influence of some agent which has the tendency and power to paralyze it, it is clear that during the first stage of paralysis, which must always be that of irritation, the symptoms must of necessity be different from what they will be in the second stage or that of actual paralysis. Many times a careful and comprehensive analysis of our case would enable us to select a remedy which would have the power of aborting, or at least

of holding in abeyance the force or disease which was steadily tending to paralysis or death of some part. If Medicine really deserves to be classed among the sciences then indeed would coming events cast their shadows before, and we would, like the astronomer, predict the eclipse while the sun shone the brightest. We would not be obliged to fight disease from one ambush to another as it steadily advanced, not knowing, or as with some, apparently not caring where the next battery might be unmasked; but, like the astronomer or scientist in other fields, we would know that such a sign, such a symptom when present, meant, undoubtedly, the subsequent appearance of certain others; that the first group meant the partial development of certain pathological changes, not directly dangerous to life nor threatening the health of the patient seriously.

I say this waiting for the full and final phenomena of a disease to develop before we begin to combat it is not scientific, and but for the fact that nine-tenths of the cases prescribed for by physicians would undoubtedly recover if left to nature alone, is all that saves the majority of us from having to openly acknowledge many defeats. This may sound harshly, but when intelligent and conscientious physicians stop to think, to realize, how much tampering and unwarranted meddling is done with the human organism by men who assume to be trained and competent, I think they will fully coincide with what I have said.

I do not wish to upbraid my professional brethren with their failings, but to show what I believe to be a way of avoiding some of them. As has been stated, *all* of the symptoms in a given case cannot always be made available for the selection of the curative remedy, at least only in a negative way. If, as a result of a thickening or hyperplasia of the spinal dura, or of certain changes in the structure of the vertebræ, slow compression of the cord occurs, is it not plain that among the first symptoms to present themselves will be those indicative of *irritation* of the cord? And will these symptoms have any greater or other significance than to locate for us the special portion of the cord involved; and while the morbid process is

developing which is giving rise to symptoms of spinal irritation, which are gradually to be followed by those of paresis or paralysis, are we making a prescription which can lay any claim to being scientific if we are using a remedy which corresponds the most closely to the various nervous phenomena present? Will the remedy be any more intelligently selected when later on we change it for one which has in its pathogenesis symptoms more closely resembling those due to the increased pressure upon the cord, which is present as a result of the unrestrained, unretarded pathological change that has been slowly developing? If in this case we had taken the totality of the symptoms and interpreted them correctly some would have been put down as reflex, and valuable inasmuch as they enabled us to locate the lesion. Others carefully translated would have told us the nature of the changes going on, and we would have prescribed a remedy in accordance with the facts of the case. That remedy would have been the same when the growth was of such proportion as to simply cause irritation and a consequent augmented functional activity of the nerve paths of the cord involved, as when it had increased to such an extent as to abolish the functions so lately stimulated, or as a result of its increased pressure, to implicate portions of the cord heretofore free.

In cases of typhoid fever and diphtheria, in which at a certain stage heart failure is liable to occur, the premonitory signs of it are almost always to be observed a greater or less length of time in advance of its actual occurrence. And when the physician does see what is impending is it not time to act before the catastrophe is upon us to such an overwhelming degree that remedies are well nigh, or entirely powerless to relieve the consequences?

It is seldom, if ever, that the paralytic symptoms develop until the nerve paralyzed, in such cases the vagus, has shown unmistakable symptoms of irritation. The physician who is familiar with the origin and distribution of this important nerve as well as with the physiology of its various branches, can read evidences of the changes to come before they have really developed in full, or to an incurable degree. In a case

of diphtheria when the throat symptoms have subsided, and the patient is considered to be out of danger so far as the primary or uncomplicated disease is concerned, it is time to look for and guard against the much dreaded heart-failure.

Too frequently is it the case that physicians, apparently, do not see or recognize evidences of heart-failure until the danger from the complication is imminent and often of a fatal nature. It is largely because they have not been trained to observe or to appreciate the initial symptoms in such cases.

Returning to the vagus, we must recall the fact that when it is irritated it causes the heart to beat slower and the respirations to proportionately increase in frequency. Let us not leave this by merely stating it as a fact, but understand just *why* it is so. The filaments from the *par vagum* sent to the heart are inhibitory in function, and when stimulated they necessarily diminish the pulsations of that organ, while those distributed to the lungs have a function which might almost be called a special sense, viz.—that of translating the irritation which results largely from an excess of carbonic acid gas, into a sense of air-hunger, or a desire for more oxygen.

If these peripheral pulmonary filaments are rendered hyperæsthetic, or more sensitive, it requires less of the normal, physiological stimulus to excite their activity, which means certainly an increased number of respirations per minute. This is the very condition which almost invariably occurs for a certain length of time before positive symptoms of paresis of the vagus are manifested.

In a case of diphtheria then, when the above symptoms appear, they almost invariably indicate the approach of paralysis or dangerous paresis at least. If you ask upon what we base this assertion, I answer, upon the *clinical history* of the case. The etiology and the clinical history of cases should be recognized as furnishing some of the essential data which will enable us to choose the correct therapeutic measures. It is quite as sensible and rational to select a remedy for the bad effects of diphtheria or scarlet fever as for "bad effects from getting the feet wet" or "from getting wet in the rain." The paralysis of cardiac or renal lea-



ions following the two diseases named are as certainly an outgrowth of them as is amenorrhœa, or rheumatism of the etiological factors last named. And it is quite as reasonable to suggest *Veratrum viride* and *Kalmia latifolia* for the complications and sequæ of diphtheria and scarlet fever, as *Pulsatilla* and *Rhus toxicodendron* for the bad effects resulting from getting the feet wet or getting wet in the rain. I do not mean to say that *Pulsatilla* always is given or needed after getting the feet wet, but merely that this is recognized as a characteristic symptom by many who will not allow other etiological factors the same importance in relation to other remedies.

The etiology of disease should be more carefully studied, particularly its significance or suggestions for the selection of remedies. Certainly the fact should not pass the therapist unheeded that in one form of Bright's disease the chief etiological factors are cold, scarlet fever, measles, malaria, acute rheumatism, etc., while in another they are syphilis, phthisis pulmonum, caries, abscesses, various wasting diseases and chronic rheumatism, while yet in a third form, alcoholism and beer-drinking are the most frequent exciting causes. Is it possible, does it seem reasonable, that such knowledge cannot, must not, be made use of by one who hopes to scientifically and successfully combat disease? This kind of knowledge will enable the physician to see below the surface, to not be so attracted or blinded or misled by the branches and leaves of the tree as not to know where or how to strike at the roots.

And this brings me back to my original statement, viz., that the physician must know how to interpret symptoms, know which are of value as therapeutic guides and which are not. By not having such knowledge it is like attempting to oppose an enemy advancing into your country and not being able to say which are the stragglers and skirmishers and which represent the main destroying army. In such a case we may employ our soldiers (remedies) in cutting off and destroying the stragglers and skirmishers, allowing at the same time the most dangerous portion of the invading army, or disease, to

advance unmolested. This is no fanciful sketch, but finds its living counterpart in those cases and those physicians who take some two or more simply accidental symptoms which are no more an indication that the remedy should be changed or based upon them than that the accompanist to a musical composition should change the key in which he was playing because there occurred an accidental sharp or flat in the melody. His fundamental notes and chords remain the same. If this were not so, and he changed his key every time there was some slight modulation or passing note in the score, he would simply be out of tune all the way through, and in the end would have furnished discord instead of harmony. So it is with physicians who are frequently changing their remedies during the course of a disease; they are simply out of tune all the way through in the hope of striking the proper key at every change.

In a case of pneumonia or typhoid fever there are always certain symptoms which have the same relation to the case, as do the symptoms of hyperæsthesia, spasmodic movements, etc., on the one hand, and anæsthesia or analgesia, or paralysis of the motor nerves on the other, to a case of slow compression of the spinal cord. Properly interpreted they signify certain things, but they do not indicate the remedy which will smother the fire of which they are only the smoke.

Physicians will often say: "I gave such a remedy for the fever, such another one for the cough, and so on for various symptoms as they appeared." And, because these symptoms disappeared during the administration of the special remedy they infer that they have checked the disease itself, whereas they have only at best, shot a skirmisher or a deserter. Such prescribing is too much like trying to fell or destroy a tree by attacking its leaves and branches. It may be done in that way, it is true, but unless the tree has almost life everlasting it will have died a natural death before the axe has touched a vital spot. So, firing these random shots around the outskirts of disease is largely a waste of time and ammunition, and the disease, if self-limited and not fatal, develops its full clinical history, passes through its various phases from its inception

to its death, and the physician has little more than kept up a pyrotechnic display for the amusement, or at best, the encouragement of the patient during the state of siege.

That remedies can and do relieve certain isolated symptoms for which they are prescribed there is no doubt or question, and why they do is easy of explanation, and, at the same time, unless selected upon better grounds than this method of prescribing affords, but little if anything is accomplished in the way of actually benefiting the patient or shortening the malady.

If diagnosis and pathology be ignored, or not thoroughly understood, no *physician*, I care not who he is, or what his attainments are in other respects, can make as accurate and scientific a prescription as he, other things being equal, who is master of these important branches. A majority of the most exclusive Hahnemannians, or symptomatologists, will say: "Oh, the pathological condition is to be taken into consideration in the light of a symptom." But how can one who knows next to nothing of pathology take it into consideration from *any* standpoint? Let such men have a case of suppuration and how soon will they prescribe *Silicea* or *Hepar sulphur*, in this case taking one of the results of the pathological process as a guiding symptom. But how is it when an abscess of some of the vertebræ occurs, or pus is formed in some location where they are not able, from want of diagnostic ability, to recognize its presence? Then it is that they fall back on reflex symptoms that have no therapeutic value whatever, and by matching a remedy as nearly as possible to this group of symptoms they expect to cure the disease. (!)

I once knew a physician who searched laboriously for a remedy which should have the symptoms of pain and tenderness in the right inguinal region, together with certain pains and peculiar sensations in the region of the groin and upper portion of the internal femoral region. Now, in reality, these phenomena of a nervous character referred to had no therapeutical value in the case at all, for all the symptoms were due to a psoas abscess, and the accidental adjacency of the genitocrural nerve to the abscess explained all of the symptoms

referable to its point of distribution. To have selected a remedy which included these "nervous phenomena," usually recognized as the most valuable upon which to base a prescription, he must have taken some remedy which through its action upon the spinal cord or periphery of this nerve had produced the symptoms searched for. In such a case a remedy selected in such a way could, of course, have no clinical value. But some one will say, "The *totality* of the symptoms should have been taken into consideration." Exactly, and if the "totality" had been, then a prescription could not have been made, for no remedy would cover the totality; for either the peculiar sensations from irritation of the genito-crural nerve must be passed without recognition from a therapeutic standpoint, or else the sensations or symptoms in the inguinal region, both subjective and objective, must be ignored. As soon as this case was diagnosed "psoas abscess" my friend put the patient upon *Hepar sulphur*, for knowing *what* to look for and *where* to look for it he soon found symptoms indicating this drug sufficiently to warrant its prescription. But I have always felt that this *diagnosis*, this knowledge that *pus* was forming, carried my friend away from the true (?) Hahnemannian course he was wont to pursue, and for the nonce he was freed from that terrible nightmare, the "totality of the symptoms."

Such men as Dunham and Farrington recognized the importance of diagnosis and pathology in the practice of homeopathy, and both were capable of utilizing these important branches in their practice. Dr. Farrington says in the introductory to his course of lectures upon *materia medica*, "I hope that no diploma will be granted to any member of this class who does not study pathology."

Such words from such a man as Dr. Farrington was, a man capable of writing such a work upon *materia medica* as he has left us, should have great weight, and should keep fresh in our minds that the modern masters of *materia medica* and therapeutics not only did not ignore but clearly recognized the importance of diagnosis and pathology.

A volume might be written upon this subject, giving numberless proofs of the value of a knowledge of these branches to the physician, and showing how they can be practically applied in making a more perfect selection and application of therapeutic measures to the cure of disease.

All things equal, the best diagnostician, the best pathologist, is the best prescriber, the truest homeopath and most successful physician.

## Clinical Society Transactions.

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JOSEPH P. COBB, M. D., SECRETARY.

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JULY MEETING, 1888.

The Clinical Society convened in regular session at 8:45 P. M., in the club room of the Grand Pacific Hotel, Dr. H. B. Fellows in the chair. Dr. Mary H. Landreth was elected to membership. The report of the evening was offered and read by

### *THE BUREAU OF CLINICAL HYGIENE.*

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DR. J. E. GILMAN, CHAIRMAN.

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THE DISPOSAL OF THE GARBAGE OF THE CITY OF CHICAGO BY CREMATION.—By DR. J. E. GILMAN.—The proper disposal of the garbage of a large city is a matter worthy of the most careful consideration of the sanitarian, and in a city of the magnitude of Chicago it becomes a serious problem of what shall be done with this immense daily collection of organic material, which so readily serves as the hot-bed to promote the development of zymotic diseases.

In older cities, much that with us is useless and waste material is worked over, and scraps of leather, bones and other substances culled out to make up into articles of merchandise or for the junk shops. This economy at present in our city would be an extravagance, as we have no method of utilizing the various articles found in the scavenger wagons, as might be done in such a city as Paris, for instance.

Heretofore what the kitchen has thrown out has been collected with the ashes, and, if not too prominent a constituent, has been emptied in the streets where filling was needed. It requires no argument to prove the folly of using such substances for this purpose.

I have seen, in years past, the streets that now are fashionable resident localities, and lined with elegant buildings,

used as the dumping ground for the refuse of our markets—barrels of spoiled eggs, loads of decaying vegetables, street sweepings and house refuse, covered, perhaps, to some extent, with ashes and stable manure, and, if not in so close proximity to dwellings as to render immediate detection certain, an occasional load of night soil has been poured out surreptitiously to add its vileness to the general contamination.

This, smoothed over and a veneering of loam or sand to hide the horrible mixture, constitutes the road-bed on which children play and people live, unconscious of the danger whenever an opening is made or the street disturbed. The result of this pernicious practice has been noticed by every observant physician, in the increased intensity of any of the zymotic diseases that might appear in such localities whenever that street for any purpose was torn up; and, as is unavoidable in a new city, the laying and repair of water mains, sewer and gas pipes make an upheaval of the sub-stratum of our streets a daily occurrence in one or another locality. I know of many instances of the ill effects of such street repairs and openings—cases of diphtheria and scarlatina, coming with a virulence and with such overwhelming force as to render the best efforts of the physician nugatory, following closely upon street repairs or grading preparatory to paving.

For a number of years the health commissioner for Chicago has endeavored to devise some method of obviating this cause of disease, and during the last five years has been in correspondence with different cities where the garbage has been disposed of by cremation. This has been done to some extent in the old world. Glasgow, Manchester, Berlin and other cities are burning refuse in variously constructed furnaces. In Montreal a furnace called the Mann Furnace was in operation, and the assistant commissioner, H. P. Thompson, was detailed to investigate its workings and report on its practicability for use in Chicago. In Pittsburgh a furnace had been constructed that was doing fairly good work, in a small way; also in Des Moines. These the commissioner, Dr. DeWolf, examined; also one in Milwaukee.

The results of the correspondence and the personal inves-

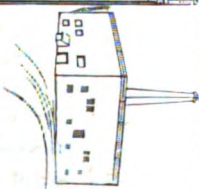
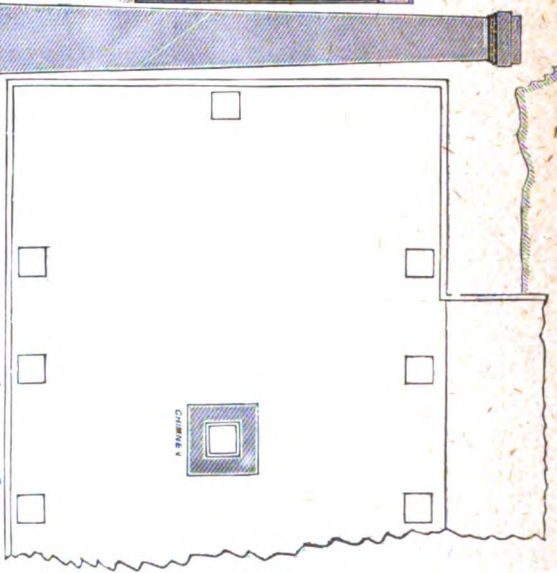
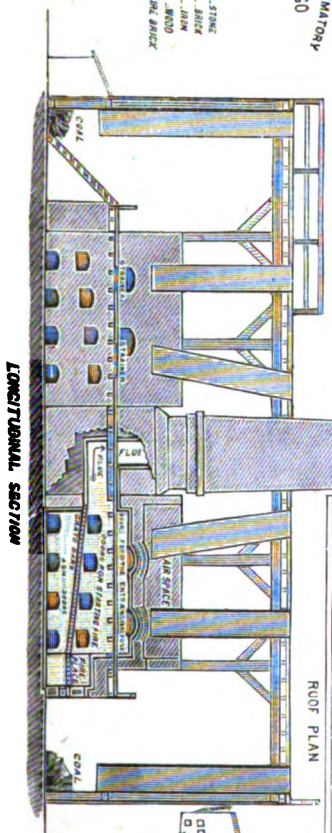
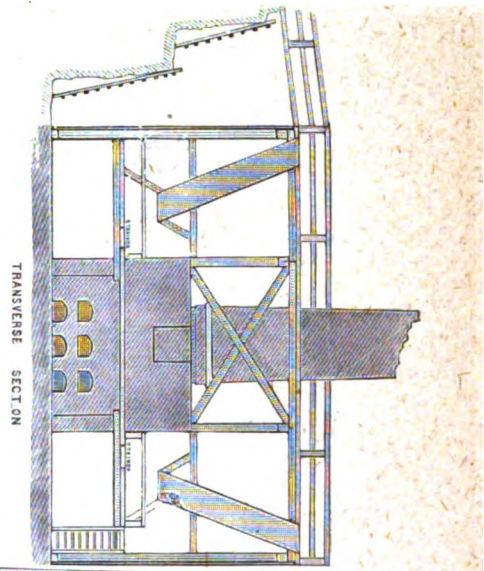
tigations were submitted to the mayor (himself a practical mechanic) and the city engineer, and, all things considered, the Mann Furnace in use at Montreal seemed to be best adapted to use in Chicago. This furnace, as operated in Montreal, was caring for the refuse of 180,000 people—burning up the night soil as well as the garbage, and doing it without offensive odor or other objectionable features. Accordingly the city council made an appropriation of \$10,000 to erect a plant as an experiment in this city.

In the northwestern portion of Chicago, near the junction of Western Avenue and Indiana Street, there is an extensive excavation where large quantities of stone have been quarried. This stone quarry has been nearly worked out, and a lease for five years was readily granted to place the garbage crematory there. No better locality could be found, so far as its natural advantages were concerned, the only drawback being its distance from the center of the city and the consequently long haul of the garbage it necessitated. A building was erected in this quarry to enclose the furnaces and so arranged that the roof is level with the street, the position being such that teams could drive directly upon the roof and discharge the contents of the wagons into the shutes. The building is ninety feet in length, and is pierced in the center by a chimney 100 feet in height. On the roof are twelve shutes ranged in two rows—six on each side of the central chimney. The furnace is a double one, with the furnace flame or coal fire at the extreme ends, while the flame rushes over the garbage that is rolled down through the shutes and pushed into the open doors on the sides of the furnace. Each furnace is twenty-two feet in length, eighteen feet in height and sixteen wide. There were used 169,000 brick in the chimney and casing, and for the heater 32,000 fire-brick.

After the fire is started and these fire-brick become heated the temperature is such that nothing organic can withstand its force. A dead dog melts away like a snow-ball under the blazing July sun, and the mass of soggy, compact swill in a few minutes becomes purified ash. Perhaps as severe a test of its action as has been made was the cremation of some

**GARBAGE Crematory  
CHICAGO**

- STONE
- BRICK
- ALUM
- IRON
- PAIR BRICK







three or four tons of wet and matted chicken and turkey feathers. If there is anything that would depress the action and spirit of a good, honest, hard-working fire it is this sort of material. As Bill Nye would say, "An ordinary fire would give up and kick itself to death" in an endeavor to conquer such an obstacle, but this one moved along as though unconscious of any special difficulty, and the only thing apparent was somewhat of an odor, an article that is not kept in stock as an ordinary thing at this crematory. In fact as to this point of stench, so far as the cremation is concerned, the furnace is free from all offensive odors. On the platform where the garbage is dumped there is some stench, but thirty feet away no odor was noticeable, and this little could be rendered absolutely innocuous by covering in the platform and using some cheap deodorant over the floor.

The furnace run to its full capacity will demolish 150 tons in twenty-four hours. At a rough estimate there are about 1,000 tons of garbage to be cared for each day from June to October, if all of it was properly removed. Consequently additional plants would have to be constructed in various points about the city to accommodate all interests. One in the north, one in the south and one in the southwest portion of the city would probably suffice for immediate needs. The present plant cost \$11,000, but it could be duplicated for from \$7,000 to \$8,000, as all the plans, patterns and castings are available for future use.

It is not absolutely certain that this is quite perfect, or that some modification may not be desirable; that remains for the future to determine. There can be no doubt about this, however, being a great advance as a sanitary measure for this city. Take for example one single instance. During the convention week there were removed from the Palmer House alone three tons of garbage daily, which were reduced to ashes in this place instead of being unloaded somewhere on the outskirts of the city to ferment and impregnate the air with the seeds of cholera infantum and other choleraic disorders. For smaller cities, perhaps, the Des Moines Furnace may present some advantages, as it can be run for a few

hours, and then allowed to rest, the cost of starting not being as great as in the Mann Furnace, but its capacity is not great enough for cities of over 25,000 inhabitants.

The report of Assistant Commissioner Thompson for May and June exhibits the expense attending the operating of the furnace. He says: "A cubic yard will weigh one ton generally, though where there is too much straw or banana stalks it would not weigh that amount. But my estimate of the number of tons destroyed is under the amount actually cremated during the months specified."

The test has demonstrated the fact that the larger the amount destroyed the less the cost of destruction will be. In other words, if the furnaces were run to the full capacity, the cost per cubic yard to destroy would not exceed 17 cents per ton, while in the statement hereto attached the lowest price per ton for destruction we have yet reached is about 26 cents.

Number of cubic yards destroyed per day, May.....	52
Number of cubic yards destroyed per day, June.....	108
Number of cubic yards destroyed month of May.....	1367
Number of cubic yards destroyed month of June.....	2678
Total expense labor and fuel, May.....	\$517.45
Total expense labor and fuel, June.....	689.92
Cost per cubic yard for destruction, May.....	.37½
Cost per cubic yard for destruction, June.....	.25½

I have brought this subject before the society as a topic that should be known and discussed, for the influence of the class of material that the health officers are destroying in this manner is a factor in the disease influences in our fair city of far-reaching and profound influence.

As an evil the garbage of so great a population has reached a point that is unendurable, and with the plans of the health department perfected we can soon hope to see this nuisance fully abated. As this is the first experiment on a large scale of such disposal of garbage in the United States we should feel satisfied if it were less of a success than it is. For in theory and practice it is the most important sanitary movement of the many introduced here by the health commissioner, and one that when fully adopted and put in use in all di-

visions of the city will remove a most formidable cause of soil pollution and disease germination. To the extent of its capacity it has accomplished all that its advocates could desire, and with more liberal appropriations for additional works where they are needed, with such improvements as the experience of this plant has suggested, Chicago's garbage crematory will be copied in all other large cities of the United States as a necessary sanitary measure.

*Discussion.*—**DR. E. S. BAILEY**—What fuel is used to produce combustion?

**DR. GILMAN**—Coal is used to heat the fire-brick, and the powerful draft decomposes the garbage, liberating hydrogen gas, which aids in keeping up the necessary degree of heat.

**DR. R. LUDLAM**—Is there any ash?

**DR. GILMAN**—Yes, and this may be found of some use, as it is harmless as a disease generator. It is now being analyzed by the city chemist to determine its real value.

**DR. FELLOWS**—Does this furnace take care of the night-soil?

**DR. GILMAN**—No. The night-soil is used for fertilizing purposes.

**DR. BAILEY**—Is this going to be the solution of the question of the disposal of garbage?

**DR. GILMAN**—Yes, I think it is, until we become more economical in its disposal, sorting it out for its different possible uses. It will burn all the garbage, after that only the refuse remains.

**DR. BAILEY**—In the condemnation of tainted meats by city inspectors, who cares for the condemned articles?

**DR. GILMAN**—Condemned meat is partly taken care of by the city and partly by private contract, but in years past condemned vegetables have been dumped into the streets as filling, as for instance at Ashland Avenue and Paulina Street, and repeated instances can be mentioned where symotic diseases have developed as a result of such street "improvements."

**DR. FELLOWS**—Would three more furnaces take care of all the garbage of the city?

DR. GILMAN—Yes, as it is only during the summer months that the garbage amounts to 1,000 tons per diem. During the remainder of the year it is not more than fifty per cent of that amount.

DR. LUDLAM—What is the degree of heat obtained in the furnaces?

DR. GILMAN—The exact degree of heat I do not know.

DR. CRAWFORD—Do you consider it a judicious thing to have the garbage removed during the daytime?

DR. GILMAN—The garbage-wagon should be covered.

DR. BAILEY—Is the stench from decaying meat disease-bearing?

DR. GILMAN—Not so much so to the community at large as that derived from vegetable decomposition.

DR. LUDLAM—If there is no putrefaction without germs there must be danger wherever there is a stench.

DR. GILMAN—Certainly, but putrefactive germs are not as poisonous as disease germs. Witness Bridgeport, which is built over trenches filled with the refuse product of the old slaughtering houses. The opening up of these trenches is not followed by zymotic influences, but if instead of simply decaying flesh the trenches had been filled with the refuse of animals dead of anthrax or pleuro-pneumonia the condition would be dangerous to the workmen opening the sewers.

DR. FELLOWS—Are plumbers who build and repair sewers any more sickly than others?

DR. GILMAN—I think not. They become inured to these influences and gain a resistant power that would cause more delicate organizations to succumb.

DR. BAILEY—What is the city ordinance in reference to plumbing?

DR. GILMAN—There is a State law that no building can be erected without submitting its plans to the Board of Health and receiving the approval of the department of building inspectors. They cannot close in any plumbing until the city inspector has examined the same.

DR. BAILEY—What is the best test for sewer-gas in houses?

DR. GILMAN—Oil of pennyroyal or peppermint. It is

best used by means of a small instrument invented by R. T. Crane, Esq., of this city. The instrument is used to tap the main sewer-pipe, and if the odor of the oil can be discovered anywhere in the house then sewer-gas can also escape. It determines the presence of sewer-gas, and locates the apertures through which it gains entrance with absolute certainty. A less certain way is to pour the oil down the sewer in some room that can be shut off from the house and see if it can be detected elsewhere.

DR. R. LUDLAM spoke of the satisfaction this test had given him both in his own residence and in those of several members of his professional parish.

**PUERPERAL ENDOMETRITIS FOLLOWING A BREECH PRESENTATION.** By Dr. WILLELLA HOWE, of Santa Ana, Cal.

*Case.*—Mrs. C., a primipara, aged twenty-eight. Her labor began 6 A. M. The membranes were ruptured at 9 A. M. On arriving half an hour later I found the os dilated to the size of a silver dollar; the position was the second of the breech. The pains continued quite steady all day, the os uteri becoming fully dilated about 3 P. M. The breech was well down within the pelvis, but the pains of the second stage were weak and ineffectual. At 5 P. M. I attempted to deliver with the instruments, but the blades slipped time and again, till I became discouraged. Then I tried to deliver with my hands, but made no progress.

I am confident the child died about the time I put on the blades, for a loop of the funis, which was prolapsed between the thighs, ceased to pulsate. At 6 P. M. I introduced my hand into the uterus to the fundus, and found the feet, brought them down, one at a time, and delivered the child's body.

The head was so large that it was almost impossible to draw it through the external parts. Finally, by one supreme effort I succeeded, but at the sacrifice of the perineum.

The child, a female, was twenty-five inches in length, eighteen inches around the body below the axillæ, the head measured fifteen inches in circumference from frontal to oc-

cipital bones; and its weight was fifteen pounds. All these were actual measurements, and the full weight was as recorded. The mother rallied well, but her stomach, which had troubled her for years, refused to digest the most delicate food. Gas was generated in great quantities almost continuously for three days, when this symptom yielded to *Carbo. veg.*

The temperature reached  $103^{\circ}$  at the end of the first day. The uterine pains were severe, the lochia were free but very offensive. The urine was drawn every six hours. She vomited several times during the third and fourth days. At the end of the third day the temperature rose to  $104^{\circ}$ , from which point it never varied day or night until she died, on the morning of the fifth day.

On the afternoon of the fourth day the lochia suddenly ceased. Being next door I was called directly it was discovered. It returned in about an hour, when it was profuse, but with an unbearably offensive odor. At 6:30 P. M. of the same day she suddenly became delirious, which condition lasted for two hours, when she sank into a coma, and died, at 7 o'clock the next morning.

One peculiarity of the case was the non-development of the mammary glands. The patient assured me that they were quite large when she conceived, and that they began to shrink immediately after. At the time of her delivery there was naught to be seen or felt save the nipple. A girl of ten years of age would show as well-developed breasts as she did at her lying-in.

The urine was free at all times. We tried nourishing enemata, which were retained at times. With the exception of the *Carbo. veg.* the remedies given failed in making the slightest impression. The skin was dry until the fourth day, after the lochia returned, when the perspiration became excessive. There were no chills, or chilly sensations at any time. During the period in which the lochia was suppressed I observed that one breast was slightly larger than before, but it soon shrank to its former size.

I believe that the patient died of sepsis combined with

pyæmia. The profuse perspiration and the delirium surely came after the suppression. All seemed well up to that time. Although the metritis was severe and the laceration a terrible one we had strong hopes of a favorable result until the fourth day. The lochia became purulent on the third day.

[NOTE.—Only those who have been caught with a breech case in a primipara, with an enormous disproportion between the size of the child and the vulvar outlet, can appreciate the position of our correspondent. No wonder the application of the forceps to the nates, as first advised by Prof. Meigs, failed, and no wonder the soft parts were torn by the delivery of such a very large child. The professional experience is that under the best puerperal management such cases are almost always fatal. Whether antiseptic irrigation was carefully and thoroughly practiced in this instance we are not told, but, whatever may be claimed for it in milder cases, the probabilities were against recovery when the endometritis came so soon after labor, and upon the heels of so serious a traumatism of the soft parts.—R. L.]

I.—CLIMATIC TREATMENT OF DISEASE.—BY A. K. CRAWFORD, M. D., CHICAGO.—It has not been with any great degree of alacrity that I have undertaken to write one or two brief sketches for THE CLINIQUE on the subject of Climates, but my good friend, the Editor, seems to think that I must have received some impressions, and should have formed some opinions about the different quarters of the globe through which I have traveled, and that possibly if some of these conclusions were transferred to paper they might prove to be of use to some of our fellow-physicians. Without making any promises of fulfilling his expressed wish I will endeavor to confine myself to my personal observations of climatic influences, both detrimental and beneficial, upon healthful and diseased states. In doing so the agricultural, historical and scenic conditions need not be considered, and I trust also that no prejudiced layman's enthusiasm for a particular locality, to the exclusion of all others, will be found lurking in these lines.



Now that I have begun this task I doubt not but that some of my friends would like me to produce a sort of a Nosological-geography, nicely executed in colors, so that it might be framed and hung on the office wall, and so arranged that the learned doctor, in possession of a key to the cypher of colors, might wheel about in his revolving chair and point out to the mystified patient the spot best adapted for the alleviation of his complaint. No such ingenious device have I the remotest idea of getting out at present, for, whether one is discoursing upon the climatic conditions of this continent or any other, I am of the belief that but a comparatively small part of the physical geography of the earth deserves special marking because of its high status hygienically. Consequently the Nosological Map would be mostly blank, after the manner of the dog which the boy wanted to sell for the sum of \$5 because it was "part spaniel," but who, when questioned as to what the rest of the dog was, had to acknowledge, after scratching his head, that it was "just only dog." So I am inclined to think in reference to the climatic conditions of a country, there may be portions very good and worthy of commendation, but the greater part is "just only climate" after all.

There are but three grand divisions of the earth's surface which demand the attention of the climatologist. These are the mountains, the deserts and the seas, and each of these divisions vary in sanitary importance in accordance with their latitude and meteorological attributes, while the mountain and desert divisions are still further modified by their altitude, rarefaction and purity of the air, moisture, vegetation, temperature, light and winds.

The points from which all climatic standards must be reckoned on land are necessarily the mountain ranges, which on this North American continent consist of three grand groups: The Alleghanys and neighbors in the east, the Rocky and Wahsatch more or less central, and the several Coast ranges in the west.

The eastern mountains are all of the lower and medium altitudes, but the western monsters carry their peaks to an elevation of from ten to almost sixteen thousand feet above

the level of the sea, while in their midst and lying between the separate ranges are plateaus and basins which grade from 5,000 feet above to 800 feet below the sea level, and arid desert enough to satisfy the utmost desires of salamanders unnumbered.

What more can any other continent offer in the way of variety of scene to the tourist, or of clime to the health seeker? Anything one may demand from the frigid to the torrid zones, exposed or protected, wild or cultivated, elevated or depressed, barren or verdant, may be had without crossing the sea. Yet I do not deem it advisable for the American physician to limit his study of climatic conditions and prevalent diseases to those which pertain alone to his own land. The ease and rapidity of travel now-a-days has brought about a much greater mixing of those who were formerly divided nationally and geographically.

An instance of the need to meet this condition of affairs occurred in my office only yesterday. A man who suffered greatly with hay asthma last summer and fall, and who now finds the "measley" trouble coming on its annual visit, wishes to betake himself to "old England," not because he is well-to-do, and wishes to pose in the *Elite News* as a European visitor this summer, but because England is where his nearest of kin live, and if sickness is inevitable he has the natural desire to be with them. Of course England would not do for a patient suffering with a complaint which is annually very prevalent there. To advise him to take up his permanent residence with his people would be to submit him to the chance of making him a chronic asthmatic, and of his becoming an aged man before he reaches forty. Such advice would be as silly as that of many New York physicians who send their consumptive patients to Florida, or some others we know of whose ignorance allows them to recommend elevated plains for chronic rheumatic subjects.

There are peculiarities of climate which I believe belong to America alone, therefore the study of the climatology of the Eastern Hemisphere does not necessarily aid one in drawing right conclusions in regard to that of the Western. On

the contrary, from that standpoint it would rather mislead than otherwise.

Note, for instance, the variety of temperatures in similar latitudes. The differences grow out of the direction of certain ocean currents, and of the disposition of the mountain ranges. The mountains in America stand north and south, thus dividing the continent into eastern and western slopes. This engenders advantages and disadvantages. The Louisiana darkey and the Florida ranchman do not enjoy the visitation of a Manitoba cold wave in winter, frosting their fingers and their fruits in a latitude parallel with the hot Sahara of Africa. Such would not occur did a mountain range run athwart the country, as do the Alps in Europe, the Himalayas in Asia, or the Atlas Mountains in Africa, for then the northern blasts would be broken, and the southern States would be perpetually hot.

But on the Pacific side of this continent this same mountainous division of the country furnishes for mankind the longest area from north to south of an equable climate that exists anywhere, the other chief element producing this peculiarity being the *Kiru Siou*, or Japan current, which sweeps the coast with its warm waters from Van Couver Island, in British Columbia, to Cape St. Lucas, at the extremity of Lower California. If added to these facts we look and find that California possesses all three divisions of the climatologist's desires—viz., mountain, desert, and sea, then this State ought to be a plentiful one in the matter of resorts for the sick and afflicted.

California has been too much written about by those insufficiently acquainted with it, and too much talked about by those whose purses were involved in its welfare, and consequently it has been lied about too much generally. It having been my privilege to have visited the Pacific Slope upon three separate occasions, and to have spent more than a year there altogether, experiencing both their summer and winter seasons, I make the very modest claim that I am in a better position to give a fair opinion of that fair land climatically, or otherwise, than the physician who, after staying less than forty-

eight hours in Los Angeles County, wrote a condemnatory epistle of the whole Southern country. His goggles must have been smeared with the slime of a Florida swamp for his vision to have been so blurred. They certainly were not of the orthodox green-glass variety else he surely would have seen something green about the vineyards which he proclaimed to be dead. The same vineyards which now, far from being dead, are holding up bravely to the ripening influence of the sun ten tons of the luscious fruit to the acre. But my object is not that of praising this particular State, nor any other, nor to waste my time and that of my considerate readers in repeating the senseless trash that has been put forth by insincere or inconsiderate writers.

If what I have said about California would dispose any reader to imagine that I am an optimist regarding that State, let his mind be disabused of such a notion as quickly as possible; for if there is one point stronger than another which I hold concerning California it is that cases of pulmonary tuberculosis must not be sent there by any physician valuing his reputation as a climatologist, or caring to be considered a humane being. Enough damage has already been done, enough lives been sacrificed, to bring all the fraternity to realize the uselessness of sending their tuberculous patients to the Pacific coast, for it is equivalent to consigning the large majority of them to their graves in very short order. And if again I should say that California is an excellent place for consumptives to hie to, I do not wish to be considered paradoxical, for in the first place I do not hold consumption and tuberculosis to be identical, and in the second place California has a multitude of climates, and should never be spoken of, in that regard, as a unit.

CLINICAL CASES.—BY DR. BELLE L. REYNOLDS, PHYSICIAN TO THE HOME FOR THE FRIENDLESS, CHICAGO.—1.—*One secret of success in treating measles.*—In the treatment of about 150 cases of genuine measles, including two epidemics, at the Home, I have observed that in all simple, idiopathic cases, when the children were left in the care of the nurses exclusively,

and my instructions were implicitly obeyed, they recovered without an exception, and without any sequelæ. The cases that were most troublesome, and the few that died, were cared for by the mothers who insisted upon nursing them, and who, being ignorant, indulgent and self-willed, disobeyed my instructions.

My method has been that as soon as the eruption appears in the fauces, even before the eyes are watery and the cough is pronounced, the child shall be undressed and put to bed. From that time it is not allowed to leave the bed, not even to use the vessel, until the eruption has disappeared from the body and face, a period of from four to seven days. In the case of a girl who was twenty-three years old, a blonde, in whom the eruption was like *purpura hæmorrhagica*, and who was delirious for three successive nights, this plan was successfully carried out.

As to remedies, I always begin with *Pulsatilla* and *Bryonia* in the third decimal dilution, and in hourly alternation for the first twenty-four hours. Then, unless there are incidental symptoms which necessitate a change of one or both remedies, they are given every two hours until the eruption has fully developed. Meanwhile the patient is allowed to take either warm or cold (not iced) drinks and light food, such as bread and milk, but no meat. All bathing and sponging of the body and limbs are prohibited, but the face and hands are to be washed in warm water.

If the child is doing well at the end of a week it is bathed, dressed and allowed to sit up, or to go about the room; but if there is any trouble with the eruption, or there are any complications, it must remain in bed for treatment.

Experience satisfies me that the most important part of the treatment of this disease is the nursing, that the mother is not usually the proper person to take care of these little patients, and that it is indispensable to keep them in bed during the eruptive stage. I have even carried this last requirement so far as not to allow the child to be taken up to nurse, compelling the mother to lie down beside it while nursing, and in every case where this rule has been obeyed the child has done well.

My theory is that by this means the indispensable conditions of warmth, moisture, an unvarying temperature and exemption from exposure to draughts of air are fully met. When a good and reliable nurse is in charge such instructions are easily carried out, and they certainly conduce to recovery without any opprobrious sequelæ.

2.—*Naphthaline in Whooping-Cough.*—In almost four years we have not been without some cases of whooping-cough. They are brought to the institution in all stages of the disease, and complications with lung and bowel affections and eruptive disorders are the rule and not the exception. They come from the unsanitary quarters of this and other cities, and the worst of it is that we can get no reliable history of the case, or of the treatment that it has received prior to admission. Add to this that the old and new cases are herded together and quarantined in the infirmary, and it is plain that isolation is impossible, and, that while we are protecting the majority who are well, we are increasing the risks of those who are already ill with it.

Under these circumstances we have had more trouble with this than with any other disease excepting the scabies. The usual remedies were faithfully tried, but in so far as shortening the duration of the disease, or mitigating the violence of the fit in the worst cases, they apparently failed. In a few cases the inhalation of the fumes of sulphur that had been burned for disinfecting purposes was tried, but without any marked relief. So also of the inhalation of the common illuminating gas, which was applied by means of a rubber nipple attached to a drop-light. The nipple being held in the mouth the gas was turned on slightly, and the child told to take good, long breaths, but there was no special result from it.

About three years ago I began the internal use of *Naphthaline* in the third decimal trituration, and the results have been so uniformly satisfactory that we now give it either singly or in alternation with some other remedy in every case of whooping-cough.

When we have the case at the onset of the disease we begin with the indicated remedies, whatever they may be.

After it has continued for a fortnight, and has become fully developed, I usually prescribe the *Naphthaline* in alternation every two hours with the remedy that the child has been taking, as for example *Tartar emetic*, *Belladonna*, *Kali bich.* or *Ipecac.* I have observed that the symptom for which either of these old remedies was first given will disappear more quickly and certainly with the *Naphthaline* than it would without it. In a little while there is no further use for any other remedy except the *Naphthaline*, which is given in a dry powder three times a day. The effect is to diminish the frequency and the severity of the paroxysms. It does not abort the disease abruptly but it lessens severity until it finally disappears.

I know that since we began the use of this remedy, under precisely the same surroundings and disadvantages, the duration of the disease has been shortened fully one-half. The possibility of controlling the severity of the paroxysm, with its consequent congestion and tendency to pneumonia and bronchitis, has left our little patients without any resulting sequelæ.

3.—*The Necessity for Examining the Eyes in Nervous affections.*—B. S., a girl of fourteen, sandy haired, freckled, of a nervous temperament, was always being complained of as stupid and dull of comprehension. She was not apt at her studies, was absent-minded, and if asked to get anything, although it was right before her, she did not seem to see it. She never made any complaint of her eyes, and no one supposed that any thing was wrong with them.

My attention was called to her for some slight ailment, and, becoming satisfied that something was wrong with her eyesight, I sent her to Dr. Watry's clinic at the Hahnemann Hospital. He fitted her with appropriate glasses, and from that time she was a different girl. All her stupidity and nervousness disappeared, and she attended to her duties and her studies as she should.

In another case a gentleman who was dining at a summer hotel was being served as usual by a waitress, who, though willing, seemed to be very stupid and slow in getting about. When he asked for any dish that was near and plainly in view he observed that she would pass it by, and perhaps go to another table in search of it before she could find it. It crossed his mind that she must be near-sighted, and he accordingly questioned her to that effect. She answered that she did not know it if she were so. Feeling that his surmises were correct he sent her to an oculist, who found that she was not stupid or idiotic but myopic, fitted her with glasses, and cured her forthwith.

## FOREIGN CORRESPONDENCE.

VIENNA, Austria, July 1, 1888.

Prof. R. LUDLAM.

*Dear Doctor:*—I should have written you earlier in regard to the medical work in Vienna, especially the advantages for laryngoscopic study, as you desired, but from lack of time it has been delayed. Vienna, no doubt, is the best place in the world to study any special branch of medicine, particularly laryngology, as the clinical material is most abundant, and the teaching is of the highest order, by such men as Profs. Schrötter, Störk, Schnitzler, and others, who are recognized as the highest authorities. The work is all of the most practical nature, as each case is examined and treated under the immediate supervision of the professors and assistants, most of whom speak English. This work is done in classes of from ten to thirty students, so that each one has ample opportunity for practical study, and one can have as many classes on the same subject he likes. A series of clinical lectures are included in each course. There are about 4,000 students and practitioners attending yearly in the University Hospital, which is an immense building containing 2,000 beds. The number of out-patients is truly remarkable, being from 15,000 to 20,000 yearly, all of whom are used for the practical instruction of the students. The Vienna School will always stand high in clinical teaching because the medical work of the whole empire is concentrated in the one great hospital, and every one labors for the success of this single institution.

One of the most interesting cases I have seen is that of a man fifty years of age who, five years since, had his larynx removed by Prof. Störk, on account of carcinoma, and who is now able to speak, swallow, and use the throat in any normal manner. The thyroid and cricoid cartilages and vocal cords were removed, while the epiglottis was allowed to remain, and a trachæal canula with a flexure upward to the epiglottis was inserted. The wound healed kindly, and fortunately formed two membranous bands, or false vocal cords, across the top of the tube, which, with the aid of the epiglottis, gives him a perfect use of the throat and voice, the latter, of course, in a modified degree. He wears a cork in the outer end of the tube. The disease shows no sign of returning, and the man seems in perfect health.

Prof. Billroth performed a similar operation on Monday, but as it is too early to give the result. I shall reserve it for the future. Truly yours,  
W. A. DUNN.



## Hospital Notes.

### THE CHILDREN'S CLINIC.

#### SERVICE OF PROF. LEAVITT.

CLINICAL NOTES ON INTESTINAL DISEASES OF CHILDREN.—*Congenital Deformity of the Rectum—Discovered on the Fifth Day—Operation with Relief—Subsequent Death.*—A few weeks since I delivered Mrs. S. of a male child weighing about eight pounds, and presenting every external evidence of perfect development. On the third or fourth day the nurse informed me that the boy had had no action of the bowels, and I directed her to use a suppository of castile soap, and in case that proved inefficient to give an enema. On making my next visit, on the fifth day, I was informed that various expedients had been employed without avail. The abdomen was found prodigiously distended, and responding dully to percussion; vomiting had also set in. I passed the finger into the rectum and found it nothing but a pocket or *cul de sac*, with a depth of about two inches. The day being far spent, I deferred operative interference until the succeeding morning, when, being unable to get fluctuation at any point within the rectum, I passed the large needle of the aspirator, and with considerable manipulation, after puncture and change of direction, I obtained quite a quantity of liquid feces. Withdrawing the needle, and continuing the finger as a director, I pushed the point of an Ellinger uterine dilator through the same puncture and spread the blades. The result was a flood of fecal matter. The symptoms of distress which preceded the operation were at once dispelled, and the child took the breast with avidity. Diarrhœa ensued, but it was easily brought under control, and the child for several days seemed to thrive. After a time symptoms of intestinal uneasiness with some tenesmus were manifested, though the discharges were fairly copious. The artificial opening was found considerably contracted, and I again dilated it. This

afforded slight relief, but evidence of inflammatory action supervened, and the child died at the age of twenty-one days.

Congenital deformity of this particular kind I believe to be quite rare, though I have been able to find no satisfactory *data* upon which to base my conviction. Its etiology is found in arrested development. About the fourth week of embryonic life, the posterior end of the alimentary canal, with the allantois, forms a cloaca. The anterior part of the cloaca, in which are the sexual ducts, is open, while the posterior part, which marks the site of the later-developed intestine, is closed. The two parts afterward separate by a bending of the canal at its posterior end, forming the sexual organs and rectum. The first partial septum is the primary perineum, which grows and finally separates the two passages. Defects in so intricate a development are not to be wondered at.

*Typhoid Fever with the Usual Phenomena—Large Peritoneal Abscess which was Lanced in Right Lumbar Region—Pus Presenting Unmistakable Fæcal Odor—Recovery.*—Georgie W. aet. ten years, suffered an attack of typhoid fever, which confined her to the bed for about six weeks. The disease presented the usual symptoms, including abdominal tympanites, rose spots, sordes, enlargement of liver and spleen, intestinal hemorrhage, delirium, etc. In the latter part of her sickness she developed symptoms of collapse, so well marked as to cause her attendants to send for me in the night. They were of short duration. General improvement soon set in, but proceeded in a dilatory manner. After a time I discontinued my visits, and heard nothing more concerning the case for three or four weeks, when I was again called. I found that my patient had gotten about the house and even as far as the piazza, but did not regain her strength. I learned that she had suffered no little abdominal pain. She was then in bed. On making a careful examination I was able clearly to outline a right abdominal abscess, which extended to the left of the median line. Fluctuation was distinct in the right lumbar region over an area about two inches in diameter. This spot was poulticed that night, and through it the abscess was lanced in the morning. So strong

was the intra-abdominal gaseous expansive pressure, that the escaping matter was blown a distance of four or five feet. A large quantity of pus was evacuated, and the wound kept open for a number of days. The abscess cavity was washed out several times. Discharge finally ceased, the opening healed, and the girl made an excellent recovery.

The most remarkable feature of the case was the unmistakable faecal odor of the abscess contents. It filled the house, and could scarcely be removed from my hands with long washing and brushing. I am fully persuaded that there was intestinal perforation, with escape of a small quantity of faecal matter, during the fever, but nature, the wonderful conservator, occluded the opening, and finally repaired it. This girl is now one of the most robust among my young friends.

*Verification of a few Characteristic Symptoms.*—In my practice I do not meet many cases in which the prompt and undeniable effects of homoeopathic remedies are shown. I am daily gratified to see my patients recover; but whether their restoration was justly attributable to any one remedy, I am not always able to determine. On this account it is truly refreshing to see immediate and almost startling results follow the exhibition of a single remedy, carefully chosen according to the law of similars. I append a few cases:

Charlie B., aet. ten months, had a diarrhoea for several days which did not submit to the remedies employed. *Podophyllin*, *Phosphoric acid* and *Arsenicum album* were successively tried. Finally the mother said, in response to my question concerning the odor of the stool, that not only the discharges, but the child himself smelled sour. *Hepar sulphur* in a high potency at once cured the diarrhoea.

Florence B., aet. sixteen months, had a diarrhoea for several days, with a variety of symptoms. *Calcarea carb.*, at one time, and *Lycopodium* at another, were thought to be indicated, but no relief followed their administration. Further study of the case gave me these symptoms: Stool of light color, painless, mixed with mucus, appetite good, tongue clean. I gave *Hepar sulphur* 30, which wrought a speedy cure.

Frank M., aet. two and a half years, teething, had been troubled with loose bowels for two or three days when his grandma accosted me on the street and asked for a prescription. I could get but few symptoms, and therefore gave *Ferrum phos.* Two days subsequently his grandma called at my office to say that he was no better. I gathered what symptoms I could and gave *Hepar sulphur.* Two days passed and I was called to the house. The mother informed me that decided improvement at first followed the last remedy, but the patient was again as bad as ever. The bowels were moving many times a day, with force; the stools were light yellow, and he could eat nothing without having a movement immediately afterward. I had no *Croton tig.* in my case, but sent to the office for the 200th dilution. The next day I found him nearly well, and the same remedy completed the cure.

Blanche D., aet. twelve years, had a poor appetite and a furred tongue for a few days, together with obstinate constipation. The stomach became irritable and would tolerate nothing. I gave successively *Arsenicum*, *Pulsatilla*, and *Ipecac* without effect. The vomiting continued all day. Not so much as a teaspoonful of either food or water could be borne. She had thirst, and was greatly distressed with vertigo and faintness on sitting up. *Bryonia album* 6 gave prompt relief.

Mary S., aet. six months, had been vomiting nearly all night. Her stomach would retain nothing. The bowels were slightly relaxed, the child was restless, pale, thirsty and greatly distressed. *Arsenicum* 3 relieved. Emesis ceased at once.

I have rarely obtained satisfactory effects from *Ipecac.* in nausea and vomiting. The two remedies upon which I have learned to place the greatest reliance are *Arsenicum* and *Bryonia*. When there is thirst, restlessness and ejection of everything taken into the stomach, *Arsenicum* 3 or 30 will, in most instances, control the symptom at once. If it fails to do so I resort to *Bryonia*, and usually with effect. If the stomach can retain nothing, and the nausea and vomiting are aggravated by raising the head from the pillow, *Bryonia* will almost certainly afford relief. In my experience these two remedies are capable of controlling emesis in nearly or quite ninety per cent of all cases.

## Miscellaneous Items.

Prof. Fellows has opened a down-town office at 70 State Street, with hours from 2 to 5 P. M., and Prof. Crawford at the same place, where it will be 10 to 1 if you find him. — Profs. Hawkes and Watry are off on a summer vacation. — Dr. H. K. Macomber, of Pasadena, Cal., has gone to Europe, do. Brother Ballard, of this city. — On application Prof. Bailey will send the catalogue of the old Hahnemann for 1888-89 to any one who may have failed to receive it. — Those who believe that "prevention is better than cure" will enjoy Prof. Gilman's report on "Garbage Cremation" in our present issue. — In a new weekly paper published in Philadelphia, and not in the "rowdy west," we are told that "this life is the other life," and encouraged to hope that we may "see the million-footed eternity marching on before us with the diapason of its triumph swelling in magnificent music up to the arches of heaven, holding the lullaby of home in its infinite tones of peace and love." — "Foreign Sketches, Chiefly Notes from the German Eye Clinics," by Dr. Harold Wilson, son of our clever old friend Prof. T. P., a reprint from *The Medical Advance*, is a very readable pamphlet. — Faith-cure extremists should remember the crib-bed for lunatics. — In consequence of failing to attend the last meeting of the American Institute, because of a temporary illness, Dr. D. S. Smith received a round-robin letter signed by seventeen of the Seniors who were present. — Prof. Laning will have a special clinic on the diseases of the liver and kidneys in the old Hahnemann, during the coming winter. — In answer to repeated enquiries we are glad to say that from September 1 to May 1 ensuing, worthy and interesting cases in surgery, gynecology, and obstetrics will be received into the Hahnemann Hospital free of charge. — The American Institute of Homœopathy is finally at work in line with the Illinois State Board of Health and the old Hahnemann College in their efforts to elevate the standard of medical education in this country, as witness the passage of the following resolution: *Resolved*, That from the college session for 1890-91 each and all of the homœopathic schools of America shall require of their candidates for graduation three years of medical study, including three full courses of lectures, didactic and clinical, of at least six months each.

# THE CLINIQUE.

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[No. 8.

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## Original Lectures.

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### ON SUPRA-PUBIC LITHOTOMY.

A LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, BY G. F. SHEARS, M. D., PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY.

Four weeks ago, you may remember, there was brought into the clinic, by Dr. Parsons, of Ravenswood, a patient who gave the following history:

“Æt. forty years. For fifteen years has had frequent attacks of gravel, and passed at different times small calculi. The last passed two years ago. Since that time he has had increasing pain and uneasiness in urinating. At times the stream of urine would be interrupted, to commence again after some change in position. During the last six months micturition has been frequent, and followed by spasms of pain in the rectum, anus, perineum and along the thighs. The urine dribbles away continually. The urine contains much mucus and some blood. His health is failing, and the constant annoyance and distress has made the continuance of his business impossible. An examination by the sound gives unmistakable evidence of a calculus. The click is so distinct that the patient recognizes the sound.”

At the request of the patient, the operation was made at his own home. Besides Dr. Parsons, several members of the class were present. To-day the following extract from a letter from Dr. Parsons announces the result. “Dear Dr. I am glad to write the present state of the case. The wound has entirely healed, and everything is eminently satisfactory.

The urine ceased to pass through the wound the twenty-first day, and now, four weeks after the operation, the patient is out of doors walking about with considerable freedom." This history has been recalled for the purpose of inciting in you a more personal interest in the subject that I propose to present to you to-day, viz., Lithotomy in the Treatment of Vesical Calculi.

Lithotomy, like many other methods in the treatment of disease, has had a varied history. Different forms of operations have had their rise and fall in popularity, and to-day, in the progress of surgery, one of the almost abandoned methods has been revived, and now holds a prominent place in the treatment of stone in the bladder. Long before the Christian era stone in the bladder was recognized by the Hindoos, and successfully treated by what is known in medical literature as "cutting upon the gripe," or the apparatus minor, the latter name being given because of the small number of instruments required, and the former from the manner of operation, which consisted essentially of cutting through the perineum upon the stone held in the grip of the fingers. It consisted of three steps: First, causing the stone to fall toward the neck of the bladder, by striking the patient between the shoulders or stroking the abdomen; second, grasping the stone and pushing it toward the perineum, by means of the fingers in the rectum and above the pubes; third, cutting upon the stone when it bulged the perineum. The operation, though rude and often fatal, was the prevailing method for many centuries.

Early in the sixteenth century changes began to be made in the method of operating, and in 1524 Marianus Sanctus described the operation known as the apparatus major. He did not cut into the bladder, but into the urethra, dilated the neck of the bladder, and removed the stone. Without going deeper into this most interesting subject of the history of lithotomy, it may be said that the supra-pubic method was discovered and described by Franco in 1561, and that the lateral operation, as now practiced, dates its definite existence to Frere Jacques, who lived from 1651 to 1714. The excessive mortality of the supra-pubic method prevented many

from adopting it, and after the perfecting of the lateral method by Cheselden, the great English surgeon, in the early part of the eighteenth century, the high operation was almost entirely abandoned, and, until the last ten years, was but rarely practiced. With the advent of antiseptic surgery, the perfection of the technique in operating, and the wonderful success of abdominal surgery generally, the high operation has received increased attention, until now its enthusiastic followers declare that within ten years the supra-pubic operation will be the operation adopted for all cases of stone in the bladder that are not treated by Bigelow's method (crushing). While an allowance must be made for the natural ardor of an enthusiastic operator, the fact remains that the old prejudice against the operation is fast disappearing, and the operation is being rapidly accepted as a valuable surgical procedure.

To-day, then, two operations present themselves for consideration in the treatment of stone in the bladder, by means of lithotomy. Each has its advantages and disadvantages, and I believe a careful survey of the subject will show each has its definite and well defined place. The supra-pubic method, anatomically considered, would seem to be a desirable operation. There are no important structures, except the peritoneum, lying in the line of incision, or sufficiently near to be liable to injury by the knife or forceps, and that membrane by the present method is pushed out of harm's way. There are no large vessels, and therefore no danger of hemorrhage; a large space is obtained for removal of the stone, and the entire area of the bladder is easily examined. It possesses one great disadvantage, the greater possibility of peritonitis and urinary infiltration. The perineal operation has the disadvantages of being made in close proximity to important structures the rectum and the pelvic arteries, it divides the prostate and seminal ducts, it permits of but a small opening into the vesical cavity, it does not allow perfect examination of the vesicle wall. It presents one great advantage, perfect drainage, and as a result almost entire freedom from septic troubles. This latter statement is only true when the stone to be removed is small enough to pass through the incision without great laceration



of the wall of the bladder. It is this point, the size of the stone, which really determines the question in the selection of a cutting operation.

The comparative results of the high and low operation, the size of the stone being taken into consideration, is best shown in the following table prepared by Gross:

		Lateral Operation.		Supra-pubic Operation.	
		No of Cases.	Rates of Death.	No. of Cases.	Rates of Death.
Under 3 1 to 2 2 to 3 3 to 4 4 to 5 5 to 6 6 to 7	i.....	529	1 in 11.25	14	1 in 4.66
	i to ii.....	119	1 " 6.61	21	1 " 6.25
	ii to iii.....	35	1 " 2.18	14	1 " 3.50
	iii to iv.....	11	1 " 1.57	19	1 " 8.16
	iv to v.....	5	1 " 1.66	16	1 " 2.28
	v to vi.....	2	1 " 2.00	11	1 " 2.75
	vi to 3 vii.....	2	1 " 1.00	2	1 " 2.00

This table clearly shows the advantage of the perineal operation in all stones weighing one ounce and less, and the great advantage of the supra-pubic method in the removal of larger stones. Since the publication of this table individual operators have made very favorable and very unfavorable reports, but none of them have had a sufficient number of cases upon which to base any general conclusions. Indeed, in comparison with results obtained in perineal lithotomy, as reported by Freyer, 143 cases without a death or Zelt, 106 cases with three deaths, the mortality is still excessive. Dennis, in a paper read before the American Surgical Association in 1887, enumerates 124 cases of supra-pubic lithotomy with a mortality of 14 per cent. From the cases reported he separates seven cases of death as not due to the operation, and makes the mortality 9 per cent. Even with this favorable report an analysis of such cases as are presented does not materially change the results as given by Gross.

In considering, then, the question of a cutting operation, in the treatment of stone in the bladder, the decision, other things being equal, depends upon the weight or size of the stone. The weight, previous to extraction, it is difficult to determine, but the size may be approximately measured by the sound or forceps. Careful experiments have quite definitely settled the length of the incision, which may be

made into the prostate without encroaching upon the body of the bladder, as well as the natural dilatability of the urethra. The distance from the urethra to the border of the prostate is about three-fourths of an inch. By incising the prostate right and left, the incision extends one and one-half inches. Allowing for the natural dilatability of the urethra another three-fourths of an inch, the limit of space is two and one-fourth inches. This length is reduced somewhat by the stretching of the aperture upward, to accommodate the other diameters of a stone, so that it is easily seen that any stone having a diameter greater than two inches is with difficulty removed without laceration of the bladder. Large stones, it is true, may be broken and safely removed, but if the stone is both large and hard and over two inches in diameter, it is preferably removed by the supra-pubic method. One advantage possessed by the perineal method is the opportunity it affords to treat deep urethral strictures, which it has been my misfortune to meet upon several occasions in the treatment of stone. Some of you may remember a case which was presented during the last summer term, in which the patient not only suffered from stone but also from a deep stricture. This I divided, during the progress of the operation, as in the operation for external perineal urethrotomy with benefit to the patient and without any added danger.

Let us now consider for a moment the details of the different operations. *The supra-pubic*: As in other operations upon the bladder the general health of the patient should be carefully considered. For several days previous to the operation he may be put upon a milk diet, which is not only nutritious but a soothing diuretic. If the urine is putrid the bladder may be washed out daily with a 4 per cent solution of boracic acid, a double current catheter being used. The day before the operation the bowels should be moved with castor oil, and the morning of the operation the rectum should be cleared by an enema. A few drops of aconite may be given to ward off shock and prevent chill. The hair should be shorn from the pubes, and the pubic and abdominal region thoroughly washed and scrubbed with a bichloride of

mercury solution. The patient being under the influence of an anæsthetic, the rectal colpeurynter is well oiled and passed up into the rectum above the internal sphincter. Into this are injected about twelve ounces of warm water, the quantity varying somewhat, according to the condition of the bladder and the age of the patient; in children the rectum being smaller and in old people less elastic. A silver catheter is now passed into the bladder and the urine withdrawn. Into the empty bladder is injected about six ounces of warm, borated water. This should be done slowly, the surgeon examining, from time to time, the abdominal wall, to determine the height of the bladder above the pubes, and the resistance offered to distension. By means of this dilatation and that of the rectum, the bladder is lifted from the pelvis and becomes supra-pubic, at the same time the peritoneum is lifted, leaving the anterior and non-peritoneal portion of the bladder exposed. A plug is now put into the end of the catheter to prevent the escape of the fluid, and the catheter allowed to remain, in order that it may be used as a guide to cut upon after the vesical wall has been exposed.

The patient lying on his back with hips elevated, an incision three or four inches long is made exactly in the median line. The deep fascia is incised upon the director, and the sulcus between the recti muscles sought. The muscles having been separated there is exposed a small space filled with fat and loose connective tissue. A small hole is made in the thin fascia covering the fat, the finger introduced pulp upward, and the little layer of fat pushed upward, carrying before it the peritoneal *cul de sac*. By this means the peritoneum is not even seen. If there is any doubt as to whether the peritoneum is out of danger an examination should be made to determine if there are two sliding surfaces over the sound, and if there is a distinct transverse raphe over the summit of the bladder. The cellulo-adipose tissue between the pubes and the neck of the bladder is avoided, and no attempt made to reach below the pubes, for fear that as the bladder collapses after the rectal distension is removed the low wound may favor urinary infiltration. Before opening the

bladder it should be secured in some way so that after its collapse it may be easily manipulated. This may be done by tenaculæ, or a double ligature may be passed through the walls of the bladder. The finger which has pushed up the fat is maintained in place, and the knife, with its back toward the finger, is made to penetrate the bladder, and is carried downward from one and a quarter to one and three-quarter inches, but never below the neck of the bladder. In making the incision the prominent plexus of veins on the anterior surface of the bladder should be cleanly cut through, and not tied. The hemorrhage ceases on the collapse of the bladder.

The index finger, dipped into a warm antiseptic solution, is now passed into the bladder and the stone found. The catheter is removed, the forceps introduced, and the stone removed. All débris being removed, the bladder is thoroughly washed out with a boracic acid solution and the rectal bag removed. A large, soft-rubber tube is passed through the wound to the bottom of the bladder. The tube is stitched to the integument, and is of sufficient length to reach into the urinal placed between the patients' thighs. The incision through the integument and subjacent tissue is closed in its upper third by sutures, but the bladder wall is not touched. A bi-chloride or iodoform dressing is applied, the dressing being perforated for the passage of the tube. The tube is removed at the end of a week and intermittent catheterization employed. Healing takes place in about three weeks.

This is a brief account of the method of operating in the high operation, but certain of the directions which I have given dogmatically are subjects of controversy, and certain others need to have the dangers attendant upon their practice emphasized. The distension of the bladder and rectum is not without danger. Although twelve ounces of water have been injected into the bladder without rupture, much smaller amounts have been followed by injury. Verneuil reports a case in which six ounces produced rupture of the bladder and death. In a case upon which I operated by the lateral method some time ago, the bladder was so contracted that

not more than three ounces could be injected into the organs, and the supra-pubic method, which had been contemplated, was abandoned. While, then, it is desirable to raise the bladder as far as possible above the pubes, great care should be taken that the bladder is not unduly distended. The same remarks hold true in regard to dilatation of the rectum. More than twelve ounces has resulted in laceration of its walls, and even less, under certain circumstances, may be more than needed.

The question of drainage has been answered in several ways. Guyon places two tubes of soft, red rubber, fenestrated only at the extremities, into the bladder. The tubes are united by silver wire passed through their walls, but not into their cavities, and are then stitched superficially to the lips of the wound. The bladder is washed out, the water entering one tube and coming out the other, without disturbing the dressings. Dennis advises the introduction of a soft, flexible catheter through the urethra. This is retained forty-eight hours, and is then followed by repeated catheterizations. Other surgeons have provided drainage by making an opening into the membranous portion of the urethra and passing a tube into the bladder. The division of the perineum seems unnecessary, and gives the added inconvenience of the perineal to the supra-pubic method.

Packard speaks of a glass tube similar to that used in ovariectomy, but smaller and curved in the arc of a large circle. Still others have advised the placing of the patient upon his abdomen.

The question of vesical suture is an undecided and interesting one. All recognize the advantages to be gained by union of the cut surfaces by first intention—the rapid cure of the patient, the avoidance of the inconvenience of abdominal drainage and the lessening of the danger of urinary infiltration—but the suture of the bladder presents many points of difficulty. In the first place, the walls of a bladder that contain a calculus are usually unhealthy, there is always more or less cystitis, and this pathological condition makes the walls soft and friable and unlikely to hold sutures, or to heal by primary

adhesion. The condition is different from that in laparotomy, when two peritoneal surfaces can be turned together and sutured. The incision in the high operation is not covered by peritoneum, and there remains nothing but the pathologically changed tissue into which to place sutures. Recognizing the value of the plasticity of the peritoneum, a French surgeon, Duchatelet, makes the proposition that the bladder should always be opened upon its peritoneal surface, and this statement is commented upon with favor by Villeneuve, but, inasmuch as the danger of wounding the peritoneum is the great dread of the operation, there is little probability of this plan being adopted universally. Von Antal advocates suturing of the bladder, and proposes the following method of opening it to favor union and prevent extravasation of urine. He makes an oval section of the bladder wall, and then dissects back the flap, leaving the mucous membrane intact. This is divided under the flap so that the two incisions are not on the same line. The sutures are carried through the outer and middle walls, and the mucous membrane is supposed to act as a valve.

The collected reports of bladder-suture are not very satisfactory. Garcin cites ninety-four cases of supra-pubic lithotomy, in twenty of which the bladder was closed by suture. In only two of these cases did union occur by first intention. Of the ninety-four cases, there were seven deaths from urinary infiltration, and five of these were cases in which the suture was used. In twenty-five cases collected by Schmitz there were six deaths and only four instances of primary union. In the young, and in the case of small stones, the best results were obtained.

In conclusion it may be said that, while at present the limitation of the supra-pubic operation to large stones seems to be the wisest plan, it can not be doubted that the re-establishment of the operation in its proper place has been a great gain to the surgery of the bladder.

## Clinical Society Transactions.

The midsummer monthly meeting of the Clinical Society was held in Parlor 44 of the Grand Pacific Hotel, on Saturday evening, August 4, at 8:30, Vice-President Dr. W. S. Gee in the chair. Dr. R. Ludlam, Jr., was chosen Secretary *pro tempore*. Twenty-five members were in attendance. After some routine business the Society heard

### THE REPORT OF THE BUREAU OF THE DISEASES OF WOMEN.

DR. R. LUDLAM, CHAIRMAN.

ON HOT WATER AS A TOPICAL APPLICATION IN UTERINE AND OVARIAN DISEASE.—By DR. R. LUDLAM.—In an address which I had the honor to make before the gynecological section of the American Institute a year ago, and which failed to appear in the *Transactions* because I never found time to write it out, my views concerning the use of hot water as an adjuvant, in the treatment of the diseases of women, were fully set forth. In connection with our clinical work in the Hahnemann Hospital, it surely will do no harm to repeat myself, and remind you that, while this very popular means of relief is often very useful, it may also be harmful if it is improperly applied.

#### ITS PECULIAR ADVANTAGES.

The chief merits of the vaginal douche with hot, or with very warm water, as advised by Dr. Emmet, are that it is simple and always available, and that its employment does not invalidate, or in any way interfere with the action of properly chosen internal remedies. It is also easy of application, for, if a nurse is not at hand, the patient can in many cases administer it for herself. And this remark applies to all the methods of using hot water in uterine and ovarian disease.

#### THE SEVERAL MODES OF APPLYING IT.

a. *By the Vaginal Syringe.*—Any kind of syringe that

will throw a constant stream, and with which the force of the current can be regulated, will answer. For irrigating purposes where the flow needs to be continued for a considerable time, too strong or too rapid a stream may be harmful and should be avoided. The instrument should be carefully cleansed, and not used indiscriminately for the rectum and the vagina, neither for different patients successively. The hips must be raised and the buttocks placed over a proper, not an old-fashioned, shovel-shaped bed-pan, so that the water may flow out. Care should be taken to carry the nozzle of the syringe, the central perforation of which is closed, behind the cervix, and thus to direct the current into the posterior *cul-de-sac*. In some cases especially the intermittent stream is preferable to the continuous one. The quantity of water used may vary from a half gallon to two gallons, or more. If very hot injections are given, say at the temperature of 105° to 115°, the nozzle of the instrument may be of ivory, and the external parts must be protected against scalding by the overflow. The waste-attachment should conduct to a vessel on the floor beneath the bed or table.

b. *By the Vaginal Syphon.*—Various expedients have been devised for decanting warm or hot water, medicated or otherwise, from a pan, pitcher or other vessel into the vagina. In all of them the principle is the same. The best that we have seen is the "Perfection douche," devised by Dr. H. M. Paine, of Albany, N. Y., to which a suitable hip-rest and bed-pan are attached. Whether we use this instrument, or the common fountain syringe, care must be taken not to run the current too quickly, too forcibly, or too continuously into the vagina, lest there should be a certain amount of traumatism of the parts, or lest the too stimulating effect of the dash should be followed by local depression instead of a healthy reaction. The latter is what we want in most cases and, therefore, the time, dose and mode of application must be carefully adapted to the case in hand. By slight occasional pressure upon the conducting tube the flow may easily be rendered less constant, and so regulated at will without the fatigue that was incident to working the bulb of an antiquated syringe.



c. *By Combining the Sitz-bath with Vaginal Irrigation.*—Although by means of a vaginal plug, and in certain cases by placing the patient in the prone position when the above means are employed, the vagina can be distended and kept filled with the warm water, there is a simpler and more successful means of accomplishing this object. It is to place the patient in a sitz-bath, and while she is there to have her separate the labia with the fingers, or to pass a common cylindrical, or Ferguson's speculum, so that the vagina may readily fill with the water. This latter expedient, which the patient can apply for herself, or have applied by the nurse, after the first time, secures the continuous contact of the water to the full capacity of the vagina, without fret and worry, and without placing the patient in an awkward position, or running the risk of an overflow. Moreover, it has the added advantage of the sitz-bath, which, whatever theorists may say to the contrary, is very seldom contra-indicated when the vaginal douche is called for clinically. I am fully persuaded that this is one of the most simple, practical and satisfactory methods of using warm or hot water in the various forms of intra-pelvic disease. It certainly is preferable to the all-over bath, and may be repeated from one to three times per day.

d. *By Injection into the Rectum.*—I can not do better than to quote the instructions of Dr. James R. Chadwick, of Boston, to whom we are indebted for the first practical lessons in this mode of using hot water in the treatment of rectal and pelvic disorders. He says:\*

“The method of administration of the hot rectal douche, with a view to attaining its utmost benefits, aims at securing the passage of the water in large volume to as high a point as possible in the alimentary tract, and its retention for as long a period as possible. Water is taken at as high a temperature as can be borne by the hand (110° F.); the patient is placed upon her side, preferably the right, in bed; a fountain syringe holding two quarts is employed, suspended quite low, so that the flow of water may be slow; as soon as the patient has a sensation of desire to defecate, or the rectum is felt by the finger in the vagina to be distended, the current of water is arrested for a few minutes, without the withdrawal of the

\*Transactions of the American Gynecological Society, 1880, Vol. V, page 287.

nozzle from the anus. In this way, one or two quarts of water may commonly be introduced without exciting peristaltic action. The patient must remain quiet for a quarter to half an hour, when, if not sooner, the rectum will generally have expelled a portion, if not all, of the water. I do not deem it wise for the patient to resist the expulsive action of the intestine, because it will thereby be incited to more violent efforts, which will counteract in a measure the beneficial action of the douche. I am unable to state how high in the intestine the water usually passes, but I am satisfied that it occasionally traverses the whole large intestine to the ileo-cecal valve."

The importance of freeing the rectum from mechanical and toxic sources of pain and of mischief, as factors in the constipated habit and in pelvic disease, will be conceded by the practical physician and gynecologist. The possibility of filling the capacious gut with the fluid in question, and so converting it into a flexible hot-water bag for the relief of peri-uterine congestion, suggests this simple expedient in cellulitis and peritonitis, especially when they are located at the left side or between the uterus and the rectum. In retro-uterine peritonitis, with or without hæmatocele, effusion, or suppuration, we can thus apply a hot-water poultice in immediate proximity to the parts involved. And in uterine, ovarian and rectal neuralgia the same means will often bring speedy relief. It is best, however, not to resort to this expedient during the menstrual flow. The only exception to this rule that I would advise is in case of menstrual hæmatocele, where the object of the rectal douche would be to stop the hæmorrhage, to abort the incidental peritonitis, and to stimulate the patient meanwhile.

*e. By its Topical Application to the Abdomen.*—Everybody knows that the local application of moist heat kept constantly in contact with the surface of the abdomen is an efficient means of relief in intra-abdominal and pelvic inflammation of an acute character. But it is not always remembered that in order to be most useful in such cases the compresses should be light and not heavy, and so arranged that the clothing will not become wet and disagreeable. A woman who has acute or even sub-acute peritonitis will have

her suffering increased by placing the full hot-water bag upon her abdomen, while, if she had the colic, the weight and pressure of the hot bag might bring the more speedy relief. Nor are we really filling the indication for *moist* heat when we order the hot-water bag. The best use for this expedient in any kind of peri-uterine disorder which is not purely neuralgic, as every case of simple colic surely is, is to place it as a cushion in the lumbo-sacral region, and let the patient lie upon it. By this means the sedative and soothing effect of the heat can, if necessary, be kept up for hours together. The practice of applying towels or flannels that have been wrung out in hot water, hot fomentations, is as old as the hackneyed joke about biographers adding a new terror to death. It is the first thing the nurse thinks of when the patient is suffering from acute pain in the abdomen or the upper pelvis, and if the water used is as hot as it can be borne, it never does any harm. A dry towel, or a covering of thin rubber, or of oiled silk should be used to protect the patient against taking cold. Whenever it is thought best to medicate these cloths or flannels, as for example, with hamamelis, it is much better to employ hot than either lukewarm or cold water.

#### ITS MODE OF OPERATION.

Whether we accept the old hydropathic theories concerning the *modus operandi* of water, or those of Laidlaw, Emmet or Trousseau, the following clinical propositions will be found true: (1) Either this agent is of service in the large class of cases under consideration because of its power to diminish and to disperse an intra-pelvic congestion; or (2) it is beneficial through a direct stimulation of the nervous and nutritive functions; or (3) its good effects must be ascribed to its anæsthetic influence upon the nerves of the abdominal cervix, as well as upon those which are distributed to the roof of the vagina.

The power of hot water over the local circulation in mucous and serous tissues is shown in its use as a hæmostatic, both in gynecological surgery and obstetrics. No single agent is so safe, speedy, certain and harmless in controlling

hæmorrhage; and the same property, whatever it is, that makes it so useful in the trying emergencies of ovariectomy and hysterectomy, and in the lying-in chamber, is available for the relief of local stasis and congestion within the pelvis.

Through a decided stimulation of the nervous and nutritive functions it doubtless relieves suffering, mitigates certain reflex neuroses which have their root within the pelvis, and helps to abort and to resolve away the effect of the inflammatory process.

One of the most practical suggestions that has recently been set forth is that of Doléris, in which he compares the forcible dilatation of the uterine cervix for the relief of dysmenorrhœa, hysteralgia, etc., to the expedient of nerve-stretching for the cure of other forms of neuralgia. Something akin to this, but more available and more widely useful, is the cervical, or præ-menstrual anæsthesia that can be so readily increased by the proper employment of the vaginal douche, either alone or in conjunction with the hip-bath. In exceptional cases, especially where the obstruction depends upon an acute flexion of the womb, the douche or the bath may first be taken, and the sound passed and the organ more easily repositioned afterward. Indeed, almost any kind of manipulation of a chronically diseased or displaced womb is much more readily and satisfactorily accomplished after such an application of very warm water has been made.

#### CLINICAL INDICATIONS.

a. *In Pelvic Cellulitis.*—It was for the relief and cure of this affection that Dr. Emmet first urged the employment of the prolonged vaginal douche. He specified clearly enough that its action was abortive rather than curative, and very properly tried to limit its application to suitable cases. But his disciples soon claimed that it was a specific for all sorts of pelvic inflammation, and its reckless and indiscriminate use followed as a natural and necessary consequence.

Experience has demonstrated, I think, that its clinical value in this affection is most decided in the congestive period, and also after the effusion has occurred. In the former case

it may avert the second stage of inflammation, and so cause the whole mischievous process to miscarry. In the latter it may either stimulate the resolution of the effused and half-organized fluid, or if that is no longer possible, may be relied upon to shorten the period of suppuration and to facilitate its discharge. The cases of pelvic cellulitis to which this method of local treatment is not applicable are those in which, as Dr. Emmet's latest writings have shown, the cellular tissue has been almost wholly destroyed by reason of the long continuance of the peri-uterine inflammation with recurrent abscess. I could cite many cases of the kind in which the too prolonged use of the douche in this way was the source of suffering and invalidism, which began to disappear directly the habit of using it was abandoned.

It is an exceptional case for pelvic cellulitis to occur among the unmarried, and when it does, unless the patient is decidedly scrofulous, there is not usually any very great proneness to suppuration. I have, however, seen cases in which it was more than possible that such a traumatism of the soft parts was induced by forcing the stream into the vagina, that suppuration resulted in consequence. We ought not to prescribe such a powerful means of revulsion as a routine measure in all classes of cases indiscriminately. Nor should we forget, in the treatment of pelvic cellulitis especially, that the good effects of the hot-water douche or bath, when properly applied, are very much enhanced if we enjoin upon the patient the necessity of absolute rest for some hours after it has been taken.

b. *In Pelvic Peritonitis.*—In this affection the vaginal douche is useful in those cases in which the peritonitis exists as a complication of cellulitis, especially if it is of puerperal origin following abortion or labor at term; those cases of retro-uterine inflammation in which the Douglas pouch is filled with serum, pus or blood; and in those also in which there is a chronic inflammation of the utero-sacral ligaments that is the sequel or consequence of some form of retro-displacement of the womb. But in idiopathic pelvic peritonitis, which confessedly is very rare, and in the rheumatic form of the disease,

which is comparatively frequent, the sitz-bath, the hot fomentations, the hot-water bag, or the rectal injections often give good results. In spurious peritonitis, or *peritonisme*, the hot fomentations are almost specific.

c. *In Nervous and Spasmodic Dysmenorrhœa* the quieting and relaxing effect of a warm hip-bath, or of vaginal irrigation, when taken in advance of the monthly period, is sometimes very pronounced. This effect is especially marked and grateful in those women who are the victims of over-excitement, and who need a certain amount of preparatory treatment before the flow begins, as they also need the wholesome effect of a monthly quarantine after it has come on. This result can be secured in many cases by having the patient take such a bath in the large bath-tub, in order that the lower extremities as well as the hips may be included; and if it is taken at night, on retiring, it may, if followed by sleep, induce the flow to appear promptly, and without pain before morning.

d. *In Hysteralgia*.—What we have said of the effects of hot water as a local cervical anæsthetic, applies to its use in this painful disorder. We only need to learn whether it has already been used, and perhaps abused, in a given case before deciding upon its employment, and occasionally to change or to combine the douche with some other mode of its application.

e. *In Ovaritis and Ovaralgia*.—The largest share of our cases of non-puerperal ovaritis is, evidently, rheumatic, and for this reason the local application of hot water as nearly as possible to the site of the suffering organ is many times, but not always, a useful expedient. In left-sided ovaritis, especially, the proximity of the inflamed ovary to the rectum makes the rectal douche of great service; but filling the vagina with very warm water for from ten to twenty minutes at a time, will give relief to right-handed ovaritis as well. Hot fomentations, and even the hot-water bag, when it is not too full and too heavy, may be applied to the iliac region with decided benefit. If the pain is severe and neuralgic, two table-spoonfulls of the strong tincture of *Hamamelis* to the

teacupful of hot water may be applied by means of compresses over the affected ovary. But the best remedy for pure, unmixed ovaralgia is to get the patient upon her feet and to make her walk about for a little while.

*f. In Pelvic Hæmatocele.*—There are three prominent indications for the local use of hot water in the different forms of pelvic hæmatocele: (1) To check the hæmorrhage into the peritoneal cavity, or into the extra-peritoneal tissues, as the case may be; (2) to promote the rapid absorption and removal of the effused blood and serum, and thus to abort the contingent peritonitis; and (3) to stimulate and sustain the rapidly failing strength of the patient. As already stated, it may be used not only with impunity, but with equal benefit in the menstrual form of the disease. And, fortunately, the invaluable expedient of our friend, Dr. Couch, which consists in raising the patient's pelvis and lowering the head, and keeping them there, facilitates the use of the hot water for immediate relief. Unless the case is attended by fearful and almost fatal collapse from the very outset, these expedients should be tried before resorting to laparotomy and sponging out the abdomen.

*g. As a Hæmostatic in Flooding and Intractable Menorrhagia.*—If its use was limited to the control of the hæmorrhage and to facilitating the detachment of the secundines after abortion and premature delivery, the hot douche would still be an invaluable resource. But to control an excessive loss of blood after labor at term, in subinvolution, from polypi, fibroids, and even from uterine cancer, it is equally serviceable. What we would do without it by irrigation and sponging in the plastic and graver operations of gynecological surgery, none can tell. At present I would as soon think of using a hand-saw as of resorting to any of the old-fashioned styptics and astringents in my work as an ovariologist, and yet those were the only hæmostatic resources that we had when I began that special work fifteen years ago.

*h. To Facilitate the Reposition of the Womb.*—No one, I think, has properly emphasized and illustrated the value of hot water irrigation as a means of facilitating the reduction of a

luxated uterus, especially if it be a case of long standing. It has been my good or ill fortune to see quite a number of cases in which it had already been decided that a displaced uterus could not be restored to its proper position. The patient had been told, and her doctor had insisted, that the organ was so bound down by adhesions that it could not be lifted or coaxed into place. In some of these, particularly in retro-displacements, all that was needed was to unload the bowels, to place the patient in the knee-chest position, and to pass the sound or the repositor, and carefully carry the fundus where it belonged. But in other cases, where the parts were swollen and tender, and the patient had already undergone so many trials of the kind as to dread it very much, I have advised that a stream of warm water be turned into the posterior *cul-de-sac* several times a day for fifteen to thirty minutes at a time, and after twenty-four hours or more the uterus was readily repositied.

This simple preparatory treatment has the effect to cause the lazy current of blood in the pelvic vessels to move along more rapidly, and to unload the congestion; while it relaxes the strangulated tissues, and renders the parts so insensible that there is no feeling of fear or of antagonism to whatever is necessary to be done for her relief. On the basis of practical experience I can recommend this expedient as worthy of trial by the members of the Society.

j. *To Postpone the Return of Menstrual Hæmorrhage.*—It does not often happen that we need to do anything that will adjourn the menstrual flow, but occasionally, in cases of great depletion from menorrhagia, with a too frequent recurrence of the flow, it is well enough to have a trustworthy and harmless expedient at hand for this purpose. In patients of a hæmorrhagic diathesis, especially if the blood is thin, if the hæmorrhage is due to sub-involution, to cancer, or to the climacteric, we may sometimes avert an attack and economize the strength by the use of the hot vaginal douche so soon as the symptoms of the monthly congestion appear. In this case the real indication is not to interrupt or to delay the appearance of the menses, but to anticipate and to avert the



incidental hæmorrhage until it can be controlled by proper internal remedies.

#### CONTRA-INDICATIONS.

The old rule that the possible good of any and all forms of auxiliary treatment is counter-balanced by the possible harm that they may do should lead us to employ this simple but powerful agent with care and discrimination. Clearness of indication, a thorough knowledge of the patient's clinical history, idiosyncrasies and antecedents, and a reasonable assurance that our instructions will be obeyed, are indispensable. I have no patience with the routine, wholesale, off-hand habit of advising it for the most varied conditions, and under all circumstances, as if it were possessed of very little power either for good or ill. It will not cure everything; it is not a specific for all the ills to which a woman is heir; but it will often do great good, if properly used, and it will assuredly become a source of mischief if it is abused.

It should not be advised indiscriminately at the menstrual period, neither in chronic cases of womb-tire, where the vitality of the tissues has been already exhausted through rapid child-bearing, neglect, or an excess of harsh and harmful local treatment. In chronic and relapsing peritonitis and cellulitis, while it may be of the greatest service when used temporarily and cautiously, its effect is injurious if the applications are too frequent and too long continued. In aphthous conditions of the cervical and vaginal mucous membrane, and in advanced cases of epithelioma, where the protecting envelope has been partially or wholly detached, the heat of the water cannot be borne with impunity.

A PECULIAR CASE.—By C. E. COLWELL, M. D., AURORA, ILL.—About the 8th of last September I was called to see Mrs. R., a married woman twenty-eight years of age, the mother of five children, four of whom are living, the extremes of age being nine and three. She never had had any miscarriages. She had not been unwell for two months. A week or so before I saw her, she had run about a mile for a doctor for a sick neighbor. Two or three days later she began to flow quite badly and to have labor pains. When

I first saw her, the pains had partially ceased and she was flowing only by paroxysms.

Digital examination showed what seemed to be a thinned and patulous os of about the size of a silver quarter, with some shreds of membrane hanging from it. She did not know whether anything like a fœtus had passed or not; she had seen nothing of the sort.

This same condition lasted about three days more, the flowing being copious at times, when I began to notice a foul odor of putrefaction, more marked on making an examination. As she had had her hardest pains and greatest flowing when at the privy, I concluded that the fœtus, if there had been one, must have passed at that time, and that there was left an adherent placenta. This I endeavored to remove, but could only tear away a few shreds.

On the fourth day she told me that the night before she had passed *something*, after which the pains and flowing had ceased.

The "something" proved to be a firm, dense tumor about the size of a goose-egg, smooth externally, with a short pedicle about half an inch in diameter, by which it had been attached to the uterus.

It had an opening opposite the pedicle about the size of a silver quarter, with thin, lacerated edges. The inner surface was smooth, and had quite a prominence on one side, that had bothered me when it was in the vagina.

On section it showed something resembling fibrous tissue, and here and there in this tissue quite good-sized spots of coagulated blood, also some placenta-like tissue, and one or two spots of fat, as though it had undergone partial fatty degeneration.

I think that the product of conception, whatever it had been, had occupied the cavity of this growth.

As I review this case, the only thing that I know of that might have seemed suspicious, was that the posterior *cul-de-sac* seemed too deep, but I accounted for that on the ground that the uterus was displaced.

Inasmuch as her menses had always been normal in every way, I could not think that this tumor was anything like a fibroid. It seemed most like a mole.

I send the specimen with this report, in order that you may examine it, and decide whether or not it is a mole.

ANOTHER PECULIAR CASE.—By C. E. COLWELL, M. D.,  
AURORA, ILL.—February 28th, or about five and one-half months after Mrs. R. passed the tumor, described in the first

paper, I was again called to see her for an intense headache at the vertex.

I drew out the following symptoms: It was now about the time that she should be unwell. Three days before she had vomited a little blood, as she had also done the month previous. The last time she had had her menses was Christmas day. She had got her feet wet several times. There was a loss of appetite, pain and burning in the stomach with a sense of weight, thirst, shaking chills several times a day, pain in the small of the back, downward pressure in the pelvis, and a feeling of fullness in the abdomen.

Thinking that I had a case of amenorrhœa, as the result of cold, and vicarious menstruation accompanied by malarial symptoms, I gave *Arsenicum* and *Pulsatilla*.

A week later I made an examination. The os-uteri was a long transverse slit, the result of a laceration caused by her second childbirth. The lips were everted, deep red in color, granular and very angry looking. Around the erosion the mucous membrane was slightly œdematous and purple shading off into the normal pink of the vagina. There were no cysts. The end of the cervix was enlarged, seeming like a thick button or flange on the end of the cervix, over which I could hook my finger, and feel the much smaller and normal-sized cervix above.

To a light touch over the eroded surface and its areola, the feeling was as of soft velvet under the finger, while firm pressure revealed the hard touch of the cervix. The rim of the collar was somewhat œdematous, but its bulk was firm and hard. The cervix was partly bathed in a very tenacious, starchy substance, and partly in just as tenacious a transparent albuminous fluid.

I cautiously attempted to introduce a sound; it easily passed in for a distance of five inches. There was no tenderness of the endometrium.

The condition that now suggested itself was subinvolution, existing since the abortion last September.

But she had had no menorrhagia, or metrorrhagia, and it would hardly seem possible that the uterus would be so large at only the second month of pregnancy, even although no involution had occurred. However, on this theory, I gave *Secale* in connection with the *Arsenicum* for several weeks. I continued to see her once a week.

The malarial symptoms disappeared, as did all others, except that occasionally she had a few pelvic symptoms of uneasiness, due to the pressure of the enlarged uterus.

The depth of the uterus remained unchanged. The cervix

looked worse and larger as it became more cedematous. The abdomen kept increasing in size, and I began to question if there were not some malignant or benign tumor growing there. Something certainly pressed hard on the right iliac vein, and the pressure was increasing because the veins of the right leg and foot were badly varicosed and painful.

About the last of the third month since her menses ceased, the suspicion of extra-uterine pregnancy arose and took its place with the already long list of possibilities.

I watched the case and could not decide whether it was uterine or extra-uterine pregnancy, epithelioma or some kindred trouble, or whether it was an eccentric parenchymatous metritis.

On the 8th of May she felt motion. This, figuring from the last time she was unwell, was four and one-half months. The uterus still measured five inches.

A couple of weeks or so later I could easily feel what seemed to be the child's head pressing low down against the front of the cervix; could easily get a *ballotement*; and could count the foetal pulse (about 140 per minute) low down and to the mother's right, in the abdomen.

The whole enlargement seemed to me to be quite low down.

At the sixth month the cavity of the uterus still measured five inches. I could not detect *ballotement*. The foetal pulse could be heard easiest somewhat higher and nearer the median line.

That this is a case of pregnancy, there is now no doubt; but where is the child?

Is it within or outside of the uterus?

If within, why was I able to pass the sound to such a depth, and to move it about so freely, and to exert so much pressure on it, as I did before I suspected pregnancy, without causing abortion?

PROGRESSIVE ANOREXIA IN HYSTERICAL SUBJECTS.—TRANSLATED FROM JOUSSET'S CLINICAL LECTURES, VOL. II.—BY R. LUDLAM, JR., M. D.—Fifteen years ago I was called to attend a young girl, who for three years had refused almost all food, and whose decline greatly worried her family. She was sixteen years old, still had some appearance of health, although thin; she was about every day, but could only walk a little. Her principal symptom was an irresistible repugnance to food; she had first refused certain meats, then all meat, fish, eggs, bread, vegetables, and after three years had come to live almost exclusively on chocolate with cream, and candy. I do not rec-

ollect the remedies employed in this extraordinary case, but always with the same result; all attempts to conquer this disgust for food were unavailing. She was taken to the sea-shore, where she seemed to derive some benefit, but it was of short duration. Two weeks before her death she wished to recover her health, made a great mental effort, and succeeded in eating a little meat each day, but it was too late. The food was not retained by the stomach, vomiting commenced and she died with a most complete marasmus.

This occurrence impressed me seriously, and I searched for analogous cases, but did not find them.

Works on hysteria record the details of some cases of total abstinence from food for an incredible period, without any marked loss of flesh, but they scarcely mention the *progressive and fatal anorexia* of which I have related such a serious example. Briquet, however, has written a passage in which he evidently refers to this affection: "Usually this depraved appetite is accompanied by disgust for nutritious food, whence results indifference at the table, rejection of the dishes as they are offered, and, by way of compensation, fitful caprices of the appetite, the habit of eating only when away from home, and of living exclusively upon sweet-meats, pastry and fruits. When this point is reached the occasional gastralgia which has been slight, becomes serious; and the young persons who are almost exclusively subject to it, lose strength, grow pale, and are so run down that they become invalids, who suffer constantly and are doomed to die in youth without having had any other disease than a gradual wasting away.

"When this form of the disease has reached such a degree of development, it is very dangerous, and should be fought with great energy and perseverance."\*

But Briquet has nowhere indicated the "energetic means" that should be applied with such perseverance for the cure of this condition. This is to be regretted, because, as we have already seen, and shall see in the course of this lecture, progressive anorexia is not only a dangerous, but often a fatal affection. That author must have seen some cases of it, but he evidently did not follow them from the beginning to the end, and therefore his description of this particular form of anorexia is very imperfect and unsatisfactory.

Laségue † gives a better description of it, for he classes it with hysterical alienation. This invincible repugnance and almost entire rejection of food, at a certain stage of the disease, is a type of what we have called the insane impulse

\*Briquet, *Traité, clinique et thérapeutique de l'hystérie*, p. 254.

†*Archives général de médecine*, Avril 1873.

(*l'impulsion anxieuse*). Instead of being impelled to suicide, incendiarism, robbery or murder, the hysterical subject is more or less tempted not to eat.

The description of the symptoms given by Laségue is very exact, but also very imperfect. He is especially occupied with the mental aspect of the condition, and has not observed either the diarrhoea, the œdema, the ultimate vomiting, or the fatal termination. The cases which I shall report in this lecture will show that he was wrong in the statement that this form of anorexia is not followed by death, and that "hysterical patients are always more or less completely cured after some years have elapsed." They are not cured, for many have died, many are still dying, and this condition of lethality is one of the characteristics of progressive anorexia.

In the second edition of my *Elements de médecine pratique*\* I have devoted a paragraph to the description of *hysterical anorexia*. When that was written I had not read the monograph by Laségue, and the parallel between the two descriptions proves their correctness.

Here then is my description: *Anorexic hysteria*.—This form of hysteria is extremely rare. We have, however, seen two cases of it which happened in two young girls at puberty. The appetite begins to diminish day by day, the patient has an invincible repugnance to certain kinds of food, as for example, meat, and this repugnance extends progressively to all kinds of food, so that at the end of from one to three years, after having daily narrowed the list of articles taken, she eats nothing, or what is entirely insufficient for the repair of her tissues.

"The emaciation and the loss of strength increase daily, the face keeps its color, and the patient finally dies of inanition, for neither the wishes, nor the prayers and the tears of her relations can overcome this invincible anorexia. Sometimes there is vomiting in the last stages of the disease."

The comparative frequency with which we have observed this affection since our description was written, enables us to complete it, and to identify its different clinical varieties. One of these varieties is very important practically, for it is extremely chronic, and the anorexia is less complete. It is possible that it may continue for a very long time. There is another kind, the course of which is rapid, and in which the marked emaciation and the graver symptoms show themselves after a few months. There is one kind which is really periodical, and in which the anorexia develops by short attacks;

\*Volume I, 1877, page 337.

and finally, there is a complex type, in which the insuperable aversion to food is joined with other fitful and unfortunate morbid conditions, such as a disinclination to speak, or the hysterical mutism, and an aversion to sleep. We shall report some cases illustrating each of these varieties,\* and will begin with one that you have seen.

*Case 45.—The common type with a duration of three years and death from inanition.*—Mrs. N. is a young blonde with a good complexion and a fine skin, but has always been delicate. A physician who knew her before her illness told us that she was transparent. The disease began after her marriage, three years before. At first she complained much of her stomach after meals, her digestion became slow and difficult, but these symptoms were greatly aggravated during a false conception eighteen months ago.

January 17, 1879.—When I first saw her she was frightfully thin, and her feet were considerably œdematous. In spite of this, however, she felt very strong, walked well, and could dance all night; she was fresh, and of good color; the vessels had no *bruit de souffle*. The menses have been suppressed for eight months, and although the uterine cervix is quite healthy, there is an abundant leucorrhœa. She has some vaginismus, but no other symptom of hysteria.

Whenever she eats she has pains in the stomach which continue through the whole process of digestion. This process is prolonged, and she has such an inveterate, nauseating repugnance to all kinds of food that she eats almost nothing, and covers everything that she does eat with mustard. I prescribed *Nux vomica* 12 to be taken an hour before, and *Graphites* 12 an hour after meals.

January 26.—The remedies having had no effect I gave *Carbo veg.* 30.

February 2.—She has improved a little, has eaten more, but has had a diarrhœa. *Arsenicum* 6.

February 11.—Better; has no more diarrhœa; ordered to take 200 grammes of meat and the yolks of two eggs each day, and to drink the wine of Zucco with a little water. Continued the *Arsenicum*.

February 17.—Slight improvement; eating a little better, but she does not take nearly enough food; the œdema of the feet is diminishing. *Ars.* 6 before, and *Graphites* 6 after meals.

\* The second case that we had was the sister of the first one. The anorexia had the same identical character as the first, was equally resistant to treatment, but it terminated abruptly at the end of six months, after a nine days' prayer (*neurocaine*) in Paris, of which, so the relatives say, the patient was not apprised. The cure has now lasted for eight years.

March 1.—I put her on raw meat, and continued the same remedies.

March 8.—The improvement continues and the menses have appeared slightly. Same treatment.

March 21.—In spite of the remedies she has had a relapse; the pains and dyspepsia have returned; and she eats less and less. I wanted to put her on the milk diet, but she refused it absolutely. *China* 2 before, and *Graphites* 3 after meals.

April 24.—She has neglected her treatment and goes from bad to worse, excepting that her strength is incredibly good. *Sepia* 1 trituration for the leucorrhœa.

May 3.—During the whole month of May she took *Sepia* in different triturations, and tried to eat, but the diarrhœa soon returned and the swelling increased.

June.—During this month she was worse, despite the *China* and *Arsenicum*; indeed, she was badly cared for and such a mistress of her own actions that she ate almost nothing. Toward the end of the month her strength, which had held out remarkably, suddenly disappeared; the skin of the hands and fore-arms became violet and rough; she is cold all the while; the œdema increased and extended to the abdomen; the skin of the lower extremities cracked and allowed the exudation of serum; the urine was not albuminous. She left for the sea coast.

July and August.—She gained some strength and ate a little more, but a diarrhœa was easily induced; she had some palpitation and fits of suffocation; the sleep was still good; she took *China* and *Arsenicum* chiefly; the swelling lessened toward the end of her stay at the coast.

September.—She made a serious effort to eat, and really has eaten a little better, but does not relish the wine. The œdema has entirely disappeared, but the strength does not return, while the emaciation continues. She is much thinner than a consumptive; and it seems as if the inanition had gone so far that food could do her no good. She coughed a little, but auscultation discovered nothing wrong with the lungs.

October.—Despite an aliment which was sufficient, chops, a little ham and sausage, the yolks of four eggs each day, half a bottle of Zucco, and a little bread, she grew weaker every day. She had violent paroxysms of suffocation, could not sleep, and finally was taken with a severe diarrhœa and died in a few days.

You will observe that the disease began with her marriage, and that the patient had some vaginismus, a condition that is frequent in hysterical subjects. The case has presented some gastric symptoms which were very pronounced. It is certain



that the gastralgia was the first cause of the anorexia. The cases which I have cited from Briquet were of the same kind, but in ordinary gastralgia we could overcome the aversion to food, quiet the pain and choose the proper diet. To these gastric pains in our case were added the *obstinate* refusal of food which is the special characteristic of hysterical anorexia. The tendency to diarrhoea, which began eight months before death, became very much worse in the last weeks of her life. We must also note the remarkable preservation of her strength under a bill of fare that amounted to almost nothing, and her being reduced to a skeleton while the legs were oedematous! Then came the sudden failure of strength; and finally the impossibility of sustaining her with sufficient food, just as those animals which have been exposed to intense cold cannot be warmed again, and die in spite of all we can do.

The cough, the fits of dyspnoea, and the diarrhoea of the last stage suggested the possibility of phthisis. But auscultation did not furnish any signs of it, and if tubercles were afterward developed, I could not detect them.

The following cases are from my private practice:

*Case 46.—The Rapid Form.*—Miss S., a brunette of a very robust constitution, began to menstruate at thirteen. For some time each period was accompanied by extremely violent attacks of menstrual colic. This dysmenorrhœa was succeeded by an habitual headache which continued for eighteen months, during which time the flow became excessive.

She is now seventeen, and her present illness began at the close of 1879. The headache had ceased, the menses were not so copious, and the health seemed to be restored, when she began to be nervous and to lose her appetite. In March, 1880, a new symptom suddenly appeared, which was an intercostal neuralgia of the right side. From this time the disease appeared to be more serious than it had previously been. At first this neuralgia was intermittent, occurring in the evening, becoming intolerable during the night, and ceasing in the morning. An intercurrent bronchitis caused this attack to assume the form of an acute disease, during which the appetite had entirely disappeared, and the insomnia was almost complete. Auscultation, which was practiced each day, detected no lesion either of the pleura, or of the lungs. The first stage of the affection lasted three weeks, when she apparently recovered. In the month of May the intercostal neuralgia returned, but this time without the fever and the bronchitis, and from that date the trouble could no longer be controlled.

The patient's repugnance to food increased every day; at first she refused to take meat, then bread, then vegetables and finally almost everything. Meanwhile the nervous symptoms became more and more pronounced. She became very sad, and her temper was completely changed. She became obstinate, indifferent to everything, and often taciturn; she devoted herself desperately to needle-work, and if one proposed to her to eat something, to take her medicine, or said that she would feel better, she became angry and indignant. However, she ate a little food on the sly, and fitfully, as if she had stolen it. She would often pick with her fingers from the dishes that had been removed from the table, a bit of spinach or of cabbage without using the fork. When in the garden she ate green fruits, and sometimes raw potatoes. Still her food was insufficient and she lost flesh, her strength failed, the menses disappeared, and she was always cold. But in the midst of all these symptoms her face wore its usual freshness.

From the beginning of the intercostal neuralgia, I detected with this patient a certain degree of analgesia. This symptom was a little more pronounced in the left arm, but it extended to the neuralgic border. It was not complete. Pressure upon the ovarian region was most painful upon the left side.

While the neuralgia was intermittent strong doses of *Quinia sulph.* had no effect. *Ipecacuanha* and *Bryonia* easily cured the bronchitis, and *Ignatia* seemed to bring about the first arrest of the disease.

With the second attack, in the month of May, the metal-therapy was tried without success, and resort was had to hydropathy. But this treatment energetically applied (two douches each day), accomplished nothing. There was no reaction and the patient was kept warm with difficulty. I then prescribed sea-bathing, but it had to be abandoned because of the lack of reaction. This was substituted by the hydropathic use of salt-water, which was more grateful, and which, the relatives thought, had the effect to increase her strength. Nevertheless, I found her in October, after three months of treatment, much worse than she had been in July.

October 7, 1880.—*Present Condition*:—considerable emaciation, loss of strength, which however, is not in proportion with the loss of flesh, for she walks a great deal; constant feeling of coldness; very little sleep; great aversion for all food, and she "cannot eat because of nausea." Her diet is limited to three plates of soup per day, which is made as strong as possible, and a few scraps that she steals. The intercostal pains continue. She is always gloomy, and becomes vexed if

anything is said of her health or her diet. The menses have not returned in three months, and the urine is very pale.

Ten minutes' use of the inductive current each morning. *Tartar emetic* 1 trituration, 50 centigrammes in 200 grammes of water, four teaspoonfuls during the day.

October 12.—The first day the electricity lessened the pain, but after that it seemed to increase it, especially for a few hours following its application. I substituted *Ipecacuanha* 1, decimal, for the *Tartar emetic*. I explained to her the danger of the case and she began to eat a little bread.

October 15.—She was weighed; her weight being ninety-nine pounds. Food is equally repulsive, and the pain that follows eating ever so little of it is considerable. The family begged her upon their knees to swallow the yolk of an egg, and she took half a teaspoonful of it. Prescribed static electricity.

October 23.—She is a little better; her disposition is more natural, she takes each day more nourishing soups, containing rice, barley and flour, with the yolk of an egg; she also drinks the syrup of gooseberries, to which quite a quantity of beef-juice and a little brandy have been added. *Veratrum alb.* ʒ somewhat relieved the pain from taking food, and she slept better. She suffered as before with the side, and sometimes walked for half an hour in her room to allay the pain.

October 31.—Her weight has increased one hundred and twenty-five grammes. The general condition is about the same, and she is taking *Conium mac*, which appears to relieve the gastric pain. The neuralgia in the side is a little better. Sometimes she sleeps for five or six hours; again she does not sleep more than two hours, with interruptions. *She does not want to sleep any more than she wants to eat.* It is against her wish to go to bed, and when she is there she takes a half sitting posture to keep from falling asleep. She eats no better.

November 4.—As the menses were due I prescribed *Pulsatilla* ʒ0, and electricity was applied to the breasts, the loins and the hypogastrum.

November 16.—The menses have not appeared; her condition is more serious; she takes a very little rice with cream and yolks of eggs morning and evening. As she drinks freely, a large quantity of strong bouillon is added to the syrups and the cocoa. She hates society, and refuses to visit any one; works harder than ever with the needle, and keeps silent. To continue the electricity and take *Sulphur* ʒ0.

November 24.—For a week past, and without knowing it, she has taken two spoonfuls of Dufresne's peptone in

Malaga wine, beside the rice and cream, and still she has lost a pound and a half in weight meanwhile. However, she looks better, is alert and walks easily; she continues to suffer with her side, especially on certain days; sleeps very badly, and persists in not retiring before 1 o'clock A. M. She rises at 6 and walks in her room for half an hour. From this period she had frequent diarrhœa, which *Veratrum* arrested, but temporarily. I ordered *Rheum* in the mother tincture, six drops in two hundred grammes of water, three spoonfuls during the day.

December 4.—She remained about the same, except that she passed better nights, and she had tried to eat at the table. She had eaten some beans, at another time some cauliflower, and an onion at another time. She is always troubled with a slight diarrhœa. Her old headaches have returned for the past four days, and are very severe. She is more sad. She takes six spoonfuls of soup containing rice and cream, with the yolk of an egg, then some bouillon with cocoa, and three spoonfuls of peptones in Malaga wine. *Pulsatilla* 200 to bring on the menses, but without effect. *Arsenicum* 3, to control the diarrhœa; this was mixed in the bouillon on account of her dislike to taking medicines. During the past fifteen days she has lost seven pounds. The electricity was stopped.

December 8.—Dr. Potain, called in consultation, prescribed peroxide of *Manganese* and powdered *Crab's eyes*, twenty-five centigrammes of each to be taken twice a day, and rubbing with a flannel saturated with benzoine vapor. He strongly advised a trip to the south of France.

For a year the disease seemed to be arrested by the influence of the southern trip during the winter, and the long stay at Spa in the summer. She now eats a little more, but is still very thin, very weak and despondent; the menses have not reappeared. She did not continue the treatment.

This case is remarkable on account of its rapidity, and represents a complete picture of the disease. Progressive refusal of all foods; desire to eat in secret; to eat strange things; considerable change in the character; preservation of color and strength, and the tendency to diarrhœa. Here we have the dislike for sleep and for society joined with that for food.

In the following case we have a true hysterical mutism with repulsion for food which is much less pronounced.

*Case 47.—Hysterical Anorexia Complicated with Mutism.*—Rosina L. is a young girl of fifteen, who began to menstruate

several years ago. I have no knowledge of her past clinical history, because I have seen her only since the commencement of her illness. The hysterical anorexia began suddenly, and soon reached its height. At the end of the year 1877, when I first saw this patient, she had been under treatment only a few weeks, but even then did not take a twentieth part of the nourishment necessary. After the unsuccessful trial of different remedies, we gave *China*, which caused a very rapid improvement. She commenced to eat a nearly sufficient amount of food, but she was then troubled with tympanitis and eructation (*musicale*), which lasted almost the entire day. As she ate enough to sustain life, I advised her to go to the country, and prescribed *Cocculus*, *Carbo veg.*, *Lycopodium* and *Chamomilla*.

Her health improved a little, but she still kept her "music," as she called it; the anorexia appeared occasionally, but never lasted very long. Rosina returned to Paris toward the end of the year 1879 for more regular treatment. The anorexia returned irregularly for a time, but her appetite was never very good, and the nourishment from it was not sufficient. The eructations became less and less. She became very peculiar, and would remain obstinately silent. Often, during my visits, I could not get a single word from her; she watched me intelligently, but stubbornly, and would not answer my questions; however, she would sometimes say yes or no, but in a low and almost unintelligible voice. At home she was always silent; she became very irritable, and when annoyed would retire to a corner and weep. She did very little, and only light housework. The menses had ceased the 20th of October, 1879; she was not emaciated, but was very weak, and this was much increased during the attacks of anorexia. *Ignatia* and *Platina* did not help her; *Stramonium*, given for the mutism, was not of service; *China* increased the appetite several times. When she ate better she would sometimes vomit during an angry fit. She returned to the country, and I heard that she remained about the same.

For a year her condition was slightly improved by *Pulsatilla*. She eats better, has gained in weight, but the menses have not reappeared. Her disposition is yet very eccentric.

The anorexia was a symptom from the commencement in this case; the mutism and the hysterical wickedness afterward became the dominant symptoms. The anorexia returns from time to time, but does not last very long. The nourishment, although below the normal, is sufficient to sustain life. We have reported this case, although very incomplete, solely to show the close relation which exists between pro-

gressive anorexia and other psychic troubles which are incident to hysteria. We shall now report a case of progressive anorexia of a very chronic nature.

*Case 48—Progressive Anorexia which is Extremely Chronic.*—Mrs. V., aged forty years, presents a case of hysterical anorexia of a very slow type. The affection began some ten years ago, when residing in the south of France. The dislike for food was slowly more and more pronounced; she at first refused red meats, then white meats, then fish and then soup; now she eats nothing but vegetables. The reason given for not eating is a feeling of fullness, which makes her believe that her food is not digested. If she yields to entreaties and eats before this sensation has passed off, she suffers with an intense headache, which confines her to bed for forty-eight hours. I observed, and spoke to her about it, that she often had the headache when she did not eat; but she believes her own explanation with the stubbornness peculiar to hysterical subjects, and against which all reasoning is without success.

For nearly a year she consented to take milk in large quantities, which arrested the bad effects of an insufficient nourishment, but since she left the country she has found the milk bad, and refused it entirely. This patient is very fleshy, her color is rosy, but her strength is very much diminished. She can barely take a few steps in the garden, remaining weeks in her room, and is often obliged to lie down for some hours during the day.

*Nux vomica* before meals, and *graphites* afterward, have given her great relief, but she soon found that the medicines disagreed with her. She had taken them very irregularly. It became impossible to control her, on account of her stubbornness, and consequently she has neglected the treatment.

She returned to the country, and I have heard that her condition is about the same.

It is certain that by the peculiar refusal of the most nutritious food, and by her obstinacy, that this was a case of *progressive hysterical anorexia*. As this anorexia was never complete, and she was badly nourished, but nevertheless nourished, life was possible with this disease for a period of ten years. I believe that this variety of the disease is compatible with a long life, as the following case, of which I have preserved but a few notes, will show.

*Case 49.—Progressive Anorexia of a Very Chronic Type.*

—Sister M., aged sixty years. On being called to attend her, I was informed that she was suffering from cancer of the stomach in its last stages. The appearance of the patient accorded with the diagnosis. She was frightfully thin, and so feeble that she could not rise in bed, and some days could hardly speak. All food was refused, and she barely took a few spoonfuls of milk. However, there had been no vomiting, and there were no signs of a tumor. She told me that for more than twenty years the amount of food taken had gradually lessened, but that, especially during the past three years, the nourishment had become so poor that extreme emaciation and weakness had resulted. When asked why she had gradually cut off her food, she said she had an invincible repugnance for it, and besides, the taking of anything solid would occasion such distress that she thought she would die. She wished that her suffering might not be prolonged. I ordered her to eat an egg, and promised her Superior to be present in case of a repetition of the attacks from which she had suffered so much. The next morning at breakfast she took an egg, and was surprised and annoyed because she had absolutely no pain. From the time she began to eat she began to improve. *Tartar emetic* ʒ seemed to aid her digestion.

This is a type of progressive anorexia with a very chronic course, and the obstinacy with which this patient gave herself up to die from inanition is characteristic. Here is a case that is remarkable for the irregular intermittency of its symptoms:

*Case 50.—Hysterical Anorexia with Irregular Paroxysms.*  
—Mrs. L., aged forty-five, who still menstruates, suffers from hysterical spasms. For some years she has been subject to attacks of complete anorexia, which usually lasted from three to four days, but which sometimes have continued for several weeks. She could not eat because of the feeling as though her last meal was not digested, and that she would be very sick if she ate again. This impossibility to eat would last for weeks. She continued this absolute diet for several days, and, if she ate too soon, only taking a spoonful of soup, or a swallow of tea, the anorexia would return and continue for twenty-four or forty-eight hours longer. Meanwhile she became somewhat pale, but continued to attend to her duties as though in good health. In these more severe attacks she became very thin and weak, and suffered from a bad and even a fetid breath.

During the interval of these attacks she ate well, and quickly repaired the effects of her abstinence. The remedies, which were taken very irregularly, had no effect on the ano-

rexia. Iron in large doses, however, once succeeded in relieving and mitigating the prolonged attacks.

This case does not belong to the common group of examples of progressive anorexia. In fact, with this patient the anorexia was complete, and the refusal of food was absolute during the paroxysms, whilst in the interval she had her ordinary appetite. However, it was evidently hysterical, and therefore progressive. For this reason I have thought it not out of place in this connection.

It should be remembered that progressive anorexia is not always as serious as may be supposed from the above cases. There are some cases that are relatively benign, in which the anorexia diminishes little by little, and disappears more or less completely in a few years. I know a certain number of young girls who present only some traces of this affection; one who never eats bread; another who refuses well-cooked meats; a third who eats very little, but still maintains fair health. A young girl who suffered for three years with this disease was cured by the waters at Aix-en-Savoie, but has maintained a great dislike for all well-cooked meats.

Progressive hysterical anorexia is, therefore, characterized by a dislike more or less pronounced for all food, by an impulsive tendency to eat sweets or acids; to eat in secret; by a change in disposition, becoming headstrong and easily provoked; the development of signs of inanition; wasting away, weakness, chilliness and oedema; by the progressive march of the symptoms; and by the gravity of the affection on account of its often terminating in starvation and death. Almost always other symptoms of hysteria are observed, as mutism and aversion to sleep. The duration of this disease when it terminates fatally is from one to three years, and when recovery follows, it is much longer; the cure is usually imperfect, and the patient continues to have a capricious and irregular appetite.

In justification of the name which we have given to this affection—*progressive hysterical anorexia*—we know that it is progressive because it commences insidiously, and increases until the almost complete cessation of nutrition. The patient first refuses one or two kinds of food, as, for example, beef, or bread, and then some weeks or months afterward, according to the development of the disease, ceases to eat mutton; then all meats are refused; then fish, of which she ate for a time, disgusts her. It is the same with eggs, and then vegetables. The range of acceptable food becomes smaller and smaller, and finally nothing but sweets and acids are accepted. This anorexia is serious, because it ends in death, or else it



persists for so long a time that the constitution of the patient is forever ruined. I would add that this affection is rebellious to all remedies. The cases, which are given not only show the powerlessness of remedies, but of the most varied treatment, as hydropathy, electricity of all kinds, sea-bathing, travel, etc.

Finally, we have declared this anorexia *hysterical* because we found in the majority of the cases analgesia, insane impulses, and in some, true fits of hysteria. It is wrong, according to our ideas, to attach this anorexia to *chlorotic dyspepsia*. The above cases, it is true, present many symptoms of chlorosis: diminution, then the suppression of the menses, the loss of breath, palpitation, œdema, and an anæmia that is due to inanition. But these are certainly the symptoms and lesions which are the result and direct consequence of anorexia. At the commencement not a single symptom of chlorosis was found, while some of them retained throughout their good color of the face, lips and mucous membranes, which excluded all thoughts of chlorosis. In this disease the anorexia is primary, and the anæmia secondary; while in chlorosis the anorexia, the depraved taste, and the dyspepsia, are symptoms which belong to an advanced period of the disease. We would also add that the anorexia of chlorosis never has the progressive march of hysterical anorexia, and especially that it never becomes so absolute.

We should distinguish progressive anorexia from the two similar conditions which are sometimes found in hysterical subjects: inanition on account of the inability to swallow, and from abstinence.

*Total abstinence* in hysterical subjects is an extremely rare affection, and consists in absolute refusal of both liquid and solid food, and for a time, which may be prolonged, with the relative preservation of plumpness. This symptom is not progressive as in anorexia, it is absolute and habitual, and comes and goes suddenly.

*Inanition from absolute inability to swallow* is caused by a spasm of the muscles of deglutition, and not by an invincible repugnance for food; the patient wants to eat, but cannot swallow. It is impossible to confound this variety of inanition with progressive anorexia.

This lecture is not offered as a classic description of progressive anorexia in hysterical subjects. Far from that; it is rather a clinical study on a point of pathology which is yet but imperfectly understood. My description shows some necessary gaps, and perhaps errors; it is certainly very incomplete, and should not have been published for some time.

I, however, thought the facts I had gathered were sufficiently numerous to furnish the outline of this disease, and to present to my *confreres* a subject of study all the more interesting, because the affection is relatively frequent, almost always overlooked, and because the proper treatment for it remains to be discovered. I therefore appeal to the good-will of all; I solicit criticism and corrections, and especially the necessary help to arrive at the cure of a disease which, more than any other, is the despair of the family. I know of nothing that is more sad than to witness the progressive wasting away, and death by a fixed limitation, of one of these children, especially when the disease and the death seem to depend solely upon an obstinate and inexplicable refusal to take food.

In an organic disease, which kills by the disorganization of one of the viscera, it seems as if resignation is developed through the impossibility of curing the material affection which is followed by death; but, in progressive anorexia, one feels that an effort of will would bring an escape from death, and that this effort of will which we are hoping and begging for, will never come, or that it will come only when it is too late, and when inanition has caused an irreparable damage. This battle of the organism, which is henceforth broken and incapable of reacting, is perhaps still more painful than the obstinate refusal of food in the first stage, because it is evident that, if the young victim had made the same efforts at an earlier period, she would have escaped death from starvation.

II. — CLIMATIC TREATMENT OF DISEASE.\* — BY A. K. CRAWFORD, M. D., CHICAGO. — Who would think of trying to describe the climate of the Atlantic Coast States from Massachusetts to Georgia in a breath? Yet this is the extent of seaboard presented by the State of California to the Pacific Ocean. The two no more resemble each other than chalk does cheese; and although, as has been already stated, the Pacific Coast climate is more uniform for a greater longitudinal mileage than any other country I know of, yet there are such meteorological differences between the north and the south, and such variations of altitude in short distances from west to east, that it requires many more breaths to convey an approximately correct idea than it does of its eastern sister coast. At San Diego the annual rain-fall is about four inches, at the northern extremity of the State bordering on Oregon it is about forty-four, and the gradation is fairly even in its increase from south to north.

\*Continued from page 227.

There are not many on our lists of invalids who require to live in a drenching rain, hence the inference is easy. In Portland, Oreg., they look confidently for the rain to begin its descent during the Fall fair-week, and they have become such a unique web-footed race that they would be sorely vexed did they not receive their full six months quota of wading through the wet.

Do they have fogs in the southern country where rain is so limited? Of course they do, and unpleasant they are to both man and beast, although I have no doubt that the green things upon the earth enjoy it. It is not an impossible thing to get beyond the reach of these fogs, and still be within sight of them, by climbing the mountain sides, and thus enjoy the clear sunshine and rare air. But the one great drawback to this is that invalids are not good climbers, and in California the mountains are not peopled, hence there are no inducements for the sick to reside in the cañons or on the crests of the ranges, for we know full well that patients who require change of climate, require also medical care and the comforts of civilization. This is the reason for my former statement that California is good for consumptives, and is not good for consumptives. I believe that tuberculous cases would do well if they could be comfortably domiciled in the Sierra Madre Range at an altitude of from four to six thousand feet, with the care, and attention, and recreation necessary to the mental health of an individual in that condition. But at present these requirements can not be fulfilled, therefore the question may be dismissed. As to the mesas and the valleys, notwithstanding the admission that they are visited by fogs, and it may be by two or three wind storms a year. I know of what I speak when I say these are the localities for patients suffering from unresolved pneumonic consolidations, whose tendency is to latent inflammations localized in the consolidated parts, to ulceration, to purulent degeneration, to cavities, to hectic, to emaciation, to harassing cough and all the readily recognized symptoms attendant upon consumption. And consumption it is, beyond a doubt, but not tuberculous. The patient had an attack of pneumonia "back in the States" from which he never fairly recovered. The exudation was not resolved, his lung action remained impaired and he did not regain his former strength. If he stays where blizzards prevail, and is exposed, another attack, or perhaps a third, will surely finish his career. Such patients flourish as "the green bay tree" in the settled and civilized valleys and mesa lands of the southern half of the State, and extend their years of existence some decades.

They must needs be careful, and not expose themselves in a saturating fog, nor to the chilling night air, but allowing for these restrictions, the weak and the robust of health have all granted them over three hundred days a year of clear, intense sunshine, and wholesome air. But these very conditions, especially the drop in the temperature at sundown, added to the dust in summer, are very provocative of nasopharyngeal catarrh, so much so that I think this complaint is fully as prevalent there as it is in Chicago. After having become acclimated, if a sanitary mode of dress were adopted it would do much to allay, if not to abolish, this trouble from the permanent resident.

The reverse of this is the history of the primary tuberculous subject in the same localities. This class goes like a tinder-box aflame. The atmosphere which possesses so many of the qualities of mountain air, yet lacks the altitude, seems to set such patients on fire. Their temperature will range in the neighborhood of 104° F., and persist in spite of treatment until they are literally burned up and reduced to ashes.

The same objections which have been raised against patients moving to the hills in this country may be urged almost equally strong against its deserts. There are but few spots thereon which would stand even passably fair in the eyes of one convinced that there would be "millions in it" to abide there; while it is to be feared that, to the poor pulmonary cripple, such places would look desolate in the extreme. Not quite so bad are one or two growing towns which border on the desert, and which enjoy, possibly, the full benefits of the beautifully dry and tempered desert air. These are to be found nestling in or about the mountain passes through which the different overland trains make their ingress or egress to the fertile valleys. As an instance of this description of a habitable place for phthisis patients, may be mentioned Beaumont or Banning, in the San Gorgonia pass. At the latter named place I had the pleasure of meeting Dr. John C. King, himself an example of tuberculous phthisis, according to the diagnosis made by several reputable physicians in 1888, and an example, too, of the benefits to be derived from a judicious change of climate, for he is not only alive, but looks hearty and handsome. These towns are at an elevation of about 2,500 feet, and in the matter of their soil, air, and sunlight they put me in mind of nothing so much as certain districts of New Mexico, about which I have something very particular to say later on.

The asthmatic subject is such an erratic beggar that it is difficult to say what place is good for him and what is

not. But I have seen him scattered over the State numerously, and in the most varied scenes and atmospheres from Gospel-swamp to Barley-flat, and in each instance he has avowed that he was doing very well, and that it was utterly impossible for him to live elsewhere. There is one thing certain, and that is, if the ocean air makes our asthmatic friend wheeze, he does not need to travel more than twenty miles to reach mountain air at an elevation of 8,000 feet or less.

Chronic rheumatics claim to do well there. They never undergo such attacks as they suffered east, in fact it is seldom that the doctors there have a case of genuine inflammatory rheumatism to treat. But others, who hitherto had not known what rheumatism was, have complained greatly of rheumatic pains. That this is a result of the peculiarities of the Southern California climate no one will question, but that the condition is not a neurotic, rather than a rheumatic, one I am not prepared to assert, for certain it is that, through whatsoever means it comes, functional neuroses are developed there quite largely, and this brings me to the last of the diseases which I will consider in connection with this fair and fruitful land.

A high altitude is well known to be inimical to the health of the individual possessed of an erethistic constitution. In this wise Dry California simulates again high mountain resorts. Women there, of nervous temperament, develop a condition of erethism which, to them, is painful and intolerable to a degree. A continuance of this state brings on disturbances of function of their abdominal and pelvic viscerae, which, I believe, to be due not so much to changes in these organs themselves as to alteration in nervous transmission to them. Before visiting that State my attention had been drawn to some such peculiarity in the Pacific Slope climate, in consequence of having had to care for several lady patients some months succeeding their return from a pleasure trip out there. They complained of a sense of tension throughout their organism, a feeling that only by firm compression of the hands or jaws could they keep from going to pieces. This may suggest to the medical mind simply the borderland of hysteria, but, even granting this, there is not much comfort in the suggestion to the patient, nor will this belief relieve the condition. It is not a matter of subjugation or loss of will-power, but an effect from a continuous over-stimulation of the sympathetic nervous centres. Electric storms are unknown in that country, while the drouth and the proximity of the mountains add to the possibility of an atmosphere constantly

surcharged with magnetic or electric currents. To those who are below par in health this stimulus acts as a tonic, and if it so happens that they are not of an unduly nervous make-up the benefit derived is continuous, and they enjoy what is a source of much discomfort to some of their neighbors. Then the question arises, Where shall the Californians, who require a change, go for their health? Easily answered: To the sea, for such as have lived inland; to the mountains, whosoever have lived on the coast. Those who choose the first have before them the open road-ways to the tropics or to the icebergs of Alaska, and all within a moderately short sail. Those who need the second may revel in nightly frosts during mid-summer, or loll in the sulphur or mud-baths of the Geysers, or the Arrow-head Hot Springs. And, notwithstanding the assertion of the wise-heads at Chautauqua that their lake, at 1,400 feet elevation, is "the highest body of navigable water in the world," the Californian, without leaving his State, can luxuriate in mountain trout-fishing, and skim by sail or steam over his Mirror Lake, Bear Lake, or Lake Tahoe at 4,000, 6,000 or 8,000 feet above the level of the sea.

(To be continued.)

RECOVERY AFTER THE ESCAPE OF FECAL MATTER FROM OPENING AN ABSCESS.—*Apropos* of Dr. Leavitt's case, reported in our last issue, page 233, we offer the translation of an extract from the curious and instructive old work on surgery by Dr. J. L. Petit (*Traite des maladies chirurgicales*):

"A traveling quack, who pretended to be a surgeon, obtained permission to erect a platform in the square, at Cambridge. During his stay in the city he was called to a man who had a pretty large hernia, and upon whom the local surgeons had proposed to operate. The quack was positive the trouble was an abscess, and nothing more, and applied a salve to it. The patient discharged his doctors, and, two days later, being in a very bad way, the quack, fearing that he would lose his confidence in him also, opened the pretended abscess, from which, instead of pus, there was an escape of a bowlfull of very offensive fecal matter. The man was relieved, and a victory was claimed for the operator.

"However, those who knew better, especially those who had first seen the patient, waited in expectation of his death. But they learned, in fact, of his improvement, and finally of his perfect recovery within a month.

"Struck with astonishment, I obtained all the details possible concerning the case, and I learned that the fecal matter ran from the wound for three days only, and that the

operator had dressed it with nothing but a simple salve, which he boasted was that of Paracelsus.

"This same fellow made a second operation, in the same manner, and with the same result. He was called to some towns in Flanders for a similar purpose, and returned to Cambrai with so great a reputation that everybody praised his skill and dexterity.

"I was very sorry to have missed the first opportunity of seeing him operate, but, fortunately, I did go to him from curiosity, and, because I was young, he was not offended. He took me with him, and I saw him open a hernia with a common lancet, just as if it had been a suppurating abscess. The fæcal matter escaped, he applied his salve, and in less than a month the patient was cured."

MEDICAL POLITICS.—There are two points worthy, I think, of attention. One is that we do not put ourselves in the wrong by any *ad captandum* proceedings. The appeal to the laity I would indeed say no word to discourage; let it be freely made, but let it be after the manner of the tracts of the excellent Homœopathic League, *anonymous*. Do not let us advertise our names or our writings in such a manner as to bring ourselves into the unsavoury company of those who thus tout for practice; do not let us be open to the generally unwarrantable insinuation that we trade upon our distinctive homœopathic designation. The other point I would make is that we interpose no unnecessary barrier to conciliation by acerbity of language on our part; or by going out of our way to oppose and ridicule such things as Listerism, as vivisection, as Pasteurian preventives of hydrophobia, and so forth. As individuals, we are entitled to our opinions on these subjects, and to the expression of the same; but I must feel regret when I see homœopathic journals as such taking up positions in the controversy, and so adding fresh elements to the contention we wage with the main body of the profession. I feel, moreover, that we are sometimes wanting in the *suaviter in modo* which becomes all such discussions as ours. There is a perceptible diminution in the bitterness of tone which used to characterise the utterances from the other side: even the *Lancet* is generally civil. Let us not be behindhand in cultivating the amenities of controversy; do not make the task of our friends more difficult by saying things which "set up the backs" of our enemies.—[From Dr. Richard Hughes' *Address to the British Homœopathic Medical Society*.

## Hospital Notes.

### THE CLINIC ON PHYSICAL DIAGNOSIS.

#### SERVICE OF PROF. ARNULPHY.

*Case 19307.—Chronic Gastritis with Heart Reflexes.*—September, 1887.—A. S., æt. thirty-one, complains of severe pain in the heart. He has been suffering for the past three years with sharp pains in the præ-cordial region, radiating upward to the neck and the back of the head, and downward along the left arm. His stomach gives him much trouble, too. He vomits quite often, particularly in the morning, and there are days when he cannot retain any food at all; there is a burning in the stomach. He always feels better when that organ is empty. After meals he is apt to become drowsy. Sometimes he feels sore all over the body, and drops into a kind of dull, timid mood, with a numb and nervous feeling that is more marked on the left side. If one of those stupid spells, as he calls them, overtakes him while walking in the street he feels dizzy, his steps become hesitating, and he is compelled to lean against a wall. The bowels are costive, the tongue slightly furred. He feels weak, and has been losing flesh steadily of late. Says it all came from having drunk a great deal of cold water when over-heated, but on close questioning he owns that he formerly did not despise whisky, and has always been chewing tobacco freely. He has occasional attacks of chills and fever. He moreover states that some eight months ago he could pinch his skin all over the body without feeling it. Pulse 65. He says he has been the rounds of the hospitals without finding the slightest relief.

*Examination.*—The apex beat is normal; the heart-impulse is somewhat exaggerated at times. Auscultation reveals naught but a tendency to irregular rhythm of contraction and a marked reduplication of the second sound. No pain is elicited by pressure over the præ-cordial region proper, but there is excessive sensitiveness over the pit of the stomach and the left hypochondrium. Percussion is very painful, and, owing most likely to the contraction of the abdominal muscles determined by the pain, a dull sound is elicited over the stomach. The left lobe of the liver is enlarged and painful. The spleen is also found to be enlarged.

The case being manifestly one of gastric catarrh *a potu*, with cerebral (dizziness, hesitating walk), spinal (anæsthesia)



and mainly cardiac (angina pectori-like symptoms) reflexes through irritation of the pneumogastric, I gave *Nux vomica* 30.

The patient reported regularly and improved in a remarkable degree.

October 26.—The soreness and sensitiveness over the stomach are almost gone, and percussion elicits the normal resonance. The stupid spells are much less frequent; he has been able to work. I am unable to find any reduplication of the second heart sound, which shows that the phenomenon was a purely nervous asynchronism of the cardiac pump. *Sulphur* 30, subsequently *Lycopodium* 30, *Graphites* 6, *Conium*, *Lachesis*, *Arsenicum*, *Cactus* were used according to symptoms (such as constipation, gloomy headache, grasping feeling at the heart, burning at stomach, numb feeling all over, etc.) with satisfactory results.

July 28, 1888.—The patient reported again after a few months' absence. He has been doing well. The stomach is in much better condition, but he has still some pain around the heart. He had refrained from drinking and chewing from the beginning of the treatment. *Nux vom.* 3.

*Case 19312.—Secondary Bronchial Catarrh. Recurring Tuberculosis—Recovery.*—Oct. 15, 1887.—Mrs. M., æt. forty-one, has had a cough for the past five months, with soreness in the chest. She describes the cough as a series of little hacking spells, occurring mostly in the day time, especially in the morning, when she raises a little white, frothy mucus. She says that formerly her expectoration was yellowish and abundant, but has not been so for four months past. She now complains of a distressing pain in the left sub-scapular region, aggravated by pressure and exercise. The menses are profuse, irregular, and painful. Besides, she is greatly troubled with indigestion, bloating and frequent eructations. No family history.

*Examination.*—The chest is narrow and emaciated. A slight depression is noticeable at the left infra-clavicular region, where percussion reveals a marked dullness. By auscultation I perceive scanty sibilant râles at both apices, with a harsh, obscurely broncho-vesicular respiration at the left summit. Pulse feverish, but well developed. I was quite aware that some mischief was brewing there, but as it could not be helped for the present, and desirous of allaying the pain and the condition of the digestive organs, *Bryonia* 3 was given.

October 30.—The pain in the chest and the stomach are

better, but the cough is worse during the day. There is also great sensitiveness to cold air around the head. Pulse 96. No perceptible change in the local signs. *Rumex* 30.

November 19.—She reports much better. The cough is not so troublesome. The expectoration is now thicker and yellow, and is raised with more ease. Examination reveals a middle-sized cavity at the left apex. There is the unmistakable hollow, low-pitched, expiratory, blowing sound. When coughing a few small gurgling notes are heard. Pulse 104. *Calc. phos.* 30.

December 14.—Has taken cold, and has had a bad cough during the last week; some expectoration in the morning; has had considerable flooding and much pain during the last period. The digestive functions are good; appetite normal.

Auscultation fails to reveal any moist r le in the cavity, which, in fact, seems to be shrinking, as the breath-sound perceived under the clavicle is more like a prolonged expiratory murmur of a hollow quality than a cavernous respiration proper.

On examining the right apex, I discover a suspicious dullness and an obscure prolonged expiration. Still the general condition is more satisfactory. We return to *Rumex* 30.

March 17, 1888.—This patient now complains of a pain in the sternal region. The left apex is sound. The right apex shows a prolonged expiration of a high pitch; there is dullness, too, and depression of the chest-wall; slight febrile condition; pulse 90, and full. *Phosphorus* 30.

April 14.—Cavernous respiration at the right apex, but no moist r les are perceptible. This patient says she feels that she is improving, but has no appetite. *Nux vom.* and *Calcareo phos.* 30.

June 9.—Has been considerably better, improving every day, and gaining flesh. But the pain in the right lung has returned. Examination fails to reveal any abnormal sign except an obscure respiration of both apices. During the forced expiration of the cough, a few high-pitched sibilant r les are still perceived in the right inter-scapular region. *Arnica* and *Calcareo phos.* 30.

This case is instructive in many ways. The two attacks we have witnessed and brought to such a happy termination have not been the only ones the patient has been subjected to. If we clinically interpret her history in a sensible way, we must admit that the disease first visited her through contagion, most probably some five or six months prior to her coming to the clinic, when her right lung, I suppose, was affected. She recovered from the attack, but, as it so often happens, the

opposite apex became involved in the morbid process, and went through the stage of softening; the cavity healed, but, the right apex having been again attacked, the whole ordeal had to be gone through with once more. The remarkable feature of the case is the brave manner in which this frail-looking, elderly woman has stood the brunt of this deadly disease. This is still more striking when we reflect that that all the while, she had menorrhagia, was up and doing, and never gave up her house-work. There is a curious contrast between the powerful grasp which the disease seems to have laid on the summit of her lungs, and the poor impression it has succeeded in making upon her vital resistance. In fact it almost seems as if no general infection had ever taken place in her organism, except in a superficial way, the patient having never complained of diarrhoea or night sweats, and having never exhibited any marked hectic.

This case shows plainly that it is not the loss of lung-substance, or the number of caverns which is of importance in the prognosis of a given case, but the degree of auto-infection and of vital resistance.

It equally shows, I think, the singular activity of *Calc. phosph.* in promoting the shrinkage and the final cicatrization of cavities. We have many instances of the fact still under observation in the clinic. The rule I follow in its administration is to use it only when the caverns are dry, or at most when but very few moist sounds are present.

*Case 19320.—Aortic Insufficiency.*—November 12, 1887. Michele R., an Italian fruit-vender, forty-two years old, had rheumatism ten years ago, but has been perfectly well since. He now suffers from a pain like a pressure over the stomach. The trouble began about forty days ago. He had been working harder than usual one day, dragging a little wagon for a number of hours, and at night, when he retired, he was suddenly seized with a hard cough, blood-spitting and palpitation, which lasted all through the night, and only gave way little by little a few days afterward, when that pressure over the stomach slowly developed. The latter symptom is the only one he complains of at present. The man is of middle height, of spare habit, but has broad shoulders and good muscles; his face is characteristically pale, and his countenance, which he tries to brighten up by means of a forced smile, bears the seal of instinctive anxiety.

*Examination* of the præ-cordial region enables me to detect at once an obscure heaving motion, and to locate the apex beat in the sixth interspace, displaced about one inch to the

left. By palpation, a marked purring thrill is felt over the sternum extending to its ensiform extremity. The thrill follows close upon the beat of the carotids, which are clearly visible, and is, therefore diastolic.

Percussion shows an increase of the superficial dullness downward and to the left. The ear, applied to the base of the heart, perceives a loud diastolic blowing murmur of a rather rasping character, entirely drowning the second sound of the heart, whereas the first sound is obscured by another murmur of much less intensity. In fact, when auscultating the left ventricular and aortic areas, the only sound perceptible is a seemingly continuous murmur, with alternating qualities of intensity and harshness. But over the pulmonary area, the thumping character of the first sound and the clapping of the pulmonary flaps become distinguishable. The carotid arteries of the neck, which are bounding and vibrating, exhibit a distinct double murmur, which I find to be present equally in the carotid arteries, but not so clearly defined as in some of Durosiez's cases, which I once examined in the Paris hospitals, under his skillful supervision.

The pulse is 82, full, regular, receding, but lacks the jerky and abrupt character of Corrigan's pulse, because the insufficiency is clearly combined with a certain degree of stenosis. *Naja* 3.

November 26.—The patient reports better. The feeling of pressure is less pronounced. *Plumbum* 30.

December 3.—Improvement continues. The murmurs and the thrill are not so intense. *Plumbum* 30.

January 7, 1888.—He has been troubled with cough, which is worse at night. On examining the chest I find a pretty large patch of low-pitched sub-crepitant râles on inspiration at the base of the right lung. No perceptible dullness. As the cough had made its appearance without any evidence of cold, and according to the nature of the physical signs, I diagnosed a congestion of the right base, due to some temporary disturbance of the compensation. Still, the action of the heart-muscle was fairly good, as shown by the heart-impact and the tone of the pulse. *Aconite* and *Phosph.* alternately.

January 28.—He does not feel so well, and complains of a weakness in the chest. He sleeps badly, and must have the head propped up very high. *Crotalus* 6.

The fact that this patient did not return to the clinic, hardly surprised me, as I am inclined to take an unfavorable view of the case. His case is a remarkable one on account of the suddenness of the onset, which is the exception in aortic troubles.

No doubt the mischief originated ten years ago, with the rheumatic attack, and chronic endocarditis has been insidiously at work ever since, bringing about such inflammatory or atheromatous alterations of the aortic flaps as have resulted, first, in a slight stenosis of the orifice, which may date, perhaps, two or more years back, slowly involving compensatory hypertrophy of the left ventricle, and entirely unnoticeable to the patient; second, in a sudden rupture after an unusual strain of one or more of the flaps, at the point of least resistance, where the destructive process had undermined the fibrous structure of the organ. This abrupt disturbance of the economy of circulation accounts for the symptoms of acute pulmonary congestion, cough, hœmoptysis, and for the period of cardiac excitement which followed and gave way to *Naja*.

The reason why I think stenosis *must* have preceded insufficiency lies in the fact of the hypertrophy of the heart, which could never have attained the degree it presented inside of forty days. Had the valvular difficulty remained in *statu quo*, it is more than likely the patient might have enjoyed a protracted period of health; but the supervention of sudden incompetence of the aortic valve has rendered his condition very precarious. As it is, the left ventricle, compelled to accommodate a larger amount of blood through the aortic reflux must needs undergo some dilatation, and it seems doubtful whether it has really strength enough to carry on its work. A case of asystole may set in at any time, and unlike in the cases of mitral difficulties, prove fatal at once.

*Plumbum 30*.—I have repeatedly found very beneficial in almost all cases of atheroma, but the time of its usefulness in the present case is already passed. *Strychnia*, the *Serpent-poisons*, *Arsenicum*, *Kali Mur* (as a tissue remedy), might be tried to keep the heart-muscle up to his duties.

*Case 19338*.—*Pulmonary Stenosis at the Menopause*.—February 18, 1887.—Louisa H., æt. fifty-two, strikes us at her first appearance at the clinic by her cyanotic and wasted aspect. Her lips and tongue are bluish; the hands, on which the veins stand out swollen and hard, have a peculiar feel of warmth and moisture; the palms are of a reddish blue. In fact, the whole body seems to be bathed in perspiration, in spite of the cold season. There is a slight œdema of the ankles and legs. She tells us that she has always enjoyed good health; the only disease she can recollect is to have had several spells of intermittent fever, years ago. In October last she suffered from headache, and this coincided with her last menstruation. Then she had some trouble with her

stomach, and used to "throw up phlegm" in the morning; at the same time she began to notice a sensation of "beating in the stomach," which grew upon her so as to become quite painful at times. Within a few months she has developed a cough, and quite frequently raises a little blood in her sputa in the morning.

Walking and going up stairs make her feel out of breath. She cannot sleep on her left side at all. According to her statement she had lost forty-four pounds since October last. She complains of weakness and poor appetite. There is no history of rheumatism or heart disease in the family. Her father had had hemorrhoids, and died of them, she says. She has a daughter fourteen years old, who suffers from palpitation.

*Examination.*—Wave-like motion visible at the epigastric region. The hand perceives a strong, regular impulse in the same region, over an extensive surface. The apex-beat is found in the sixth interspace, slightly displaced to the left. The area of superficial dullness is notably increased to the right. Auscultation reveals a well-defined, slightly rasping, systolic murmur in the second left interspace, over the area of the pulmonic orifice, which is propagated upward to the left shoulder. The diastolic click is distinctly audible. The hand applied over the seat of the murmur perceives a slight thrill. Both sounds of the heart are clearly perceived when auscultating the apex, or the aortic area. No murmur is audible in the arteries of the neck.

I pronounced the case to be one of pulmonary stenosis, and do not think the diagnosis can be contested. The purely systolic character and the exact determination of the murmur exclude the possibility of mitral stenosis, wherewith only it could be confounded; and the enormous hypertrophic dilatation of the right ventricle equally excludes the hypothesis of a hæmic murmur.

The lungs, where I thought I would find signs of congestion, did not exhibit any; there are no râles of any kind, and the breath-sound is tolerably good everywhere. Only the resonance of the chest is rather poor.

The superficial veins of the neck, chest and abdomen are apparent and dilated, and the signs of venous stasis are generally very marked.

The pulse is regular and not particularly weak. The patient says the flow of urine is about normal (a subsequent examination failed to discover any albumen). Let us notice, too, a moderate hypertrophy of the thyroid gland.

Now being given the extreme rarity of the lesions of the

pulmonic orifice at the time of life of our patient, it is of interest to trace the etiology of this case.

Although Lebert cites a case of congenital pulmonic stenosis that reached the age of sixty-five, it is a well-known fact that such patients die before they are thirty; besides, the hypothesis of a congenital lesion is quite out of the question in the present instance, as this woman had an excellent health-record until October last.

This is an acquired lesion, no doubt, but what kind of lesion is it? The endocarditic origin cannot be invoked; atheromatous lesions of the pulmonary valve are extremely rare, especially in women; besides, those alterations are always attended with such deformities of the flaps as to render the second pulmonic sound very faint, or even to efface it altogether. In our case, the pulmonic sound is very well preserved. My conclusion is that the orifice proper is not the seat of the stenosis; that we are in presence of an exocardial narrowing or partial occlusion of the trunk of the pulmonary artery.

Here, however, we are confronted again by a whole array of possibilities, as to the cause of the compression of the vessel. It may be through aneurism of the ascending aorta, through enlarged mediastinal lymphatic glands, through cicatricial shrivelling of a patch of lung, or it may be through some specific tumor (exostosis).

Judging that the important fact of the trouble having made its appearance at the time of the cessation of the catamenia had to be taken in serious consideration, and desirous of testing the case, I prescribed *Lachesis* 12.

February 29.—A few days after beginning the remedy, the menstrual flux had appeared again, and at the same time she has been bleeding at her nose abundantly. Her condition is otherwise unchanged. Feeling that no effective help could be given, beyond sustaining the efforts of the overtaxed right ventricle, and that the only hope of relief laid in attempting to diminish the pressure over the artery, by reducing the size of the suspected obstructing growth, if possible, I gave *Kali Iod.* 1. (2 gr. doses a day).

March 7.—Our patient has notably improved. She has had epistaxis again several times in the morning, and expectorated dark blood mixed with slime, but she feels better. Her appetite has improved; the cough and the headache have left her. Continue *Kali Iod.* 1 trit.

This woman reported at the clinic until the end of May, and kept improving slowly. The epistaxis, the cough and the bloody expectoration ceased altogether. The limbs,

though rather stiff, were no more swollen. The appetite was good, and thanks to some *Hyosciamus* 3, which I gave her, she slept well. I had given her also *Strychnia* 3 trit. as a heart tonic. As to *Kali Iod.*, the action of this remedy was very striking—as soon as she stopped it, she felt her old ailments return.

After an absence, she returned to the clinic in July. She complains now of great weakness. The signs of venous stasis are not quite so apparent, but the thyroid gland has considerably enlarged. The tumor feels very hard, and the skin over it is tense and glossy. It follows exactly the larynx in deglutition. No pulsation or thrill can be detected by careful examination. I more than ever persist in believing that either some specific tumor, or some enlarged bronchial gland, is the cause of the pulmonic trouble. Continue *Kali Iod.* and *Strychnia*.

Should the obstacle prove to be refractory to treatment, this patient is threatened with rapid dilatation, fatty degeneration and rupture of the right ventricle.

#### THE PLAN OF INSTRUCTION IN THE HAHNEMANN COLLEGE.—(1)

The course of instruction given is so largely *clinical* and *objective* that every student is brought face to face with disease in all the departments of clinical study; (2) the College course is the complement of the daily drill in the Hospital; (3) the corps of clinical teachers in the Hahnemann Hospital is composed exclusively of those who belong to its College Faculty, and who are thus privileged to practice what they teach before the eyes and for the benefit of their pupils; (4) these Hospital facilities are amply sufficient for practical illustration without sending its students elsewhere to patch out a clinical course; (5) the lectures actually delivered in the Hospital and College are given by men of age and experience, of character, learning and reputation, of honor, dignity and responsibility; and (6) *the students are examined upon those subjects only which they may reasonably be expected to master during their pupilage, and which will best fit them for their chosen career.*



## Miscellaneous Items.

The Twenty-Ninth Annual Announcement and Catalogue of the Hahnemann Medical College and Hospital, of Chicago, with a triennial list of its 1,490 graduates, is out, and will gladden the eyes of preceptors and pupils.—Its Winter Session opens September 18.—Our exchanges record the sudden and untimely death of the very acceptable author, Dr. J. Milner Fothergill, of London.—THE CLINIQUE had a very pleasant call from Dr. Alfred K. Hills, editor of the *New York Medical Times*, and a pupil of the late Dr. Carroll Dunham, while *en route* for Colorado.—The *Pittsburg Medical Gazette* has a high opinion of the *Journal of the American Medical Association* and of the ethical hypocrisy of its Chicago management when it says: “The brazen impudence of the *Journal* in upholding the code of ethics for the guidance of other people, while constantly violating it in its own conduct, passes understanding.”—*On dit*—and we shall soon know whether we are uncle or aunt—that the Boston University School of Medicine is pregnant with a college journal.—Attention is called to the Hospital Notes taken from Prof. Arnulphy’s clinic on Physical Diagnosis as furnishing a sample of the thorough work done in the “Old Hahnemann.”—“Reflex Urethral Neuroses,” by Dr. G. Frank Lydston, etc., a reprint from the *Western Medical Reporter*, is a very suggestive paper.—Prof. Fellows will present the report on Nervous Diseases to the Clinical Society at its September meeting.—At the last meeting Prof. Leavitt was appointed to read a special paper on “The Uterine and Vaginal Douche in Post-partum Hemorrhage.”—To those who do not think as we do in medical matters, we commend the following sentiment from a popular author: “There is no one in all the world with whom it is so difficult to sympathize as with the narrow fanatics of our own particular faith.”—It is currently reported that Prof. Bailey keeps two typewriters and a lot of clerks busy with the college correspondence.—The new “*don'ts*” are *Don't* fail to secure your seats in the clinical amphitheatre of the Hahnemann Hospital, from Prof. Bailey at once; *don't* forget that the Women’s Clinic in the said hospital will give the best advantages in Abdominal Surgery and in the use of Electricity in Gynecology; *don't* fancy that you “know it all” until you have had at least one more course of lectures in the biggest and best of all the schools which, of course, is the Hahnemann of Chicago.

# THE CLINIQUE.

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CHICAGO, SEPTEMBER 15, 1888.

[No. 9.

## Original Lectures.

### ON DISINFECTANTS.

A LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE, OF CHICAGO, BY J. E. GILMAN, M. D., PROFESSOR OF SANITARY SCIENCE.

In my lecture before this class I have called your attention frequently to the germ theory of disease, and the class of disorders known as zymotic. In some of these ailments we can definitely determine the specific germ which, when introduced into the organism under conditions favoring its development, is followed by the regular and invariable result of the rise and progress of the specific disease, and unless these germs *are* present, the disease cannot exist. There are others of the zymotic diseases in which the germ has not, as yet, been discovered. By analogy, however, there is a germ there, although it has eluded discovery. The minute quantity of the contagion necessary to establish the disease, the rapid reduplication of the poison, the specific nature of the virus, one poison reproducing its kind only, and so definitely, that we know now in the advent of a disease, what its regular course is likely to be.

These and other reasons adduced and given to you, furnish us with a basis for the belief that there are disease germs, that have a definite life, and may be destroyed outside of the human body or to a considerable extent destroyed or retarded in their development in the system. Naturally, we should

then turn to experiments with substances capable of destroying or subduing these germs. Our cultures of bacteria in soils suitable for their propagation have taught some lessons of methods of weakening their power and vitality, yet if the soil be what is required for the growth and needs of the germ, the resulting product will be strong and active.

We have learned that of the germs we have observed they require differing conditions for development and nutrition, and the substance that will affect one for good or ill may not certainly affect another in the same manner. We must then experiment with one and another drug, or condition, or precautions, or methods of prevention, to determine what will interfere with generation of the germs of infection, or will destroy them when once formed.

Observation has determined that there exists a very close connection between the process of fermentation or decomposition, and the zymotic diseases. Decomposition is in progress everywhere, and *may* not of itself induce disease, but where there are decaying animal or vegetable materials, there exists the conditions favoring the growth and development of disease germs. A soil that is a hot-bed of culture is suitable for many plants; an arid plain furnishes suitable conditions for but few. The plants in the garden and the hot-bed flourish luxuriantly, those on the sand and dusty roadside are stunted and poorly nourished. A locality in which exists decomposing substances in quantity furnishes a nutrient soil, where the specific disease germs may gain that strength and vitality that shall enable them to overcome the normal vitality of the living being. It is a hot bed for disease. Our garden may not produce any plants, although admirably adapted to furnish everything necessary for their sustenance, but if the seeds are sown the plants are developed. Sterilize the soil, and the germ by the wayside dies for lack of nutrition.

Decomposition gives warning of its presence, usually, by the emission of gaseous odors of an offensive character. Sulphuretted hydrogen, ammonia, etc., as examples, and unpleasant and unwholesome as they may be of themselves, they can not, and never have, so far as heard from, produce a

solitary case of any of the zymotic diseases. They may, and undoubtedly do, lower the vitality of an individual or of a community, and, when the disease germs are sown and germinate, there is not only an increase of vigor of the virus—an intensity of poisonous influence due to the nutrition furnished by the decomposing substances—but there is also a lessened power of resistance on the part of the victim, and the disease assumes what is known as a virulent epidemic, or malignant form.

The odor of decomposition is a warning of danger, and the removal of the odor in the minds of many is equivalent to the suppression of the whole offending substance. Yet bacterial life may not be interfered with, and *vice versa*. The really dangerous constituent of a foul cellar or cess-pool may still exist in full vigor, while the odor is stifled with a deodorizer, while a disinfectant may be a very unsatisfactory substance as a deodorizer, and have a very good effect as a destroyer of poisonous gases or bacterial life.

“A disinfectant, then, is a substance that destroys or renders inert that which produces disease, whether of an infectious or a contagious type. It is also a substance which arrests these putriferous processes in decomposable material which foster, or perhaps produce, the germs, gases or vapors that induce disease in the human organism.” “An antiseptic is a substance which prevents decay in material that is liable to decomposition.” A deodorant is a substance that will remove odors, especially unpleasant ones. A disinfectant may at the same time be an admirable deodorizer also.

Do not make the all too-common mistake of confounding these terms. I heard awhile ago of a physician of some considerable reputation, who had attended a case of contagious disease, resulting in the death of the patient. He had personally superintended the disinfection of the house, and so reported to the board of health. He said the work had been done thoroughly. An inquiry as to the method employed disclosed the wonderful work of sprinkling coffee-grounds on a pan of coals, and the dissemination of its pleasing aroma throughout the premises. The unpleasant

odors were banished, and a delightful one substituted, but the first person who was susceptible to the disorder, who entered the premises, would find plenty of evil-disposed germs which may possibly have relished the coffee also. It is needless to add that the board of health recommended to the doctor a study of disinfection, and placed in the hands of a more competent individual the task of regenerating the premises.

Antiseptics are used to prevent the formation of the putrefactive germs, while disinfectants are used to destroy these germs after they have been already introduced. All disinfectants, then, are necessarily antiseptic in their action, and many of the antiseptics, if used in sufficiently large quantities, or intensified in action, may be disinfectants also. As examples of antiseptics, take the familiar domestic ones, such as sugar or salt, vinegar, alcohol. The action of smoke or creosote on meat; the action of heat and cold, although the two latter have many of the requirements of the disinfectant class; charcoal is a powerful deodorant, and may also be destructive to some of the variety of disease germs. So powerful an absorbent of unpleasant odors is this substance, that the body of a decaying rat which may diffuse the knowledge of its demise in every portion of a house to such a powerful extent as to drive out all the occupants, this stench may be absolutely removed by so thin a sprinkling of the charcoal as will simply cover the carcass. It oxidises and absorbs offensive effluvia very rapidly, and will stand as a fair example of its class. Impure water filtered through charcoal will be relieved of its decomposing organic matter, but experiments made by Drs. Chaumont and Notter show that it allowed fresh organic matter, such as fresh-egg albumen, to pass through to a large extent unchanged, and if not frequently renewed would presently begin to disgorge its absorbed impurities, and impregnate the water again.

As I said there is a close connection between the process of putrefaction and diseases of a zymotic class. Therefore, as good sanitarians, we must remove all animal and vegetable refuse and excreta, as speedily as possible from any locality

where its fermentation changes might influence public health. The more promptly we do this, the less necessity there will be for the use of disinfectants, and the disposition made of this refuse often is a great problem, which you, as members of the medical fraternity, will be called upon to solve.

To produce putrefaction or fermentation, requires a moderate degree of heat and moisture. A temperature over 55° Fahrenheit and under 100, is suitable; with this must be a certain freedom of circulation of air. Animal and vegetable substances that would putrefy readily are preserved by drying the material. Even the putrefactive process may be checked in its progress in this manner. But if the condition of moisture be restored, the decomposition proceeds as though there had been no interruption. The effects of heat and cold in their influence on putrefactive change, are well known. The cold suspending the action of the baccillus, benumbing and rendering it temporarily harmless, while heat at the boiling temperature destroys the germs. The liquids used as soils, for the cultivation of the bacteria, are sterilized by repeated boiling.

Fire, of course, will destroy the deleterious substances, and the furnace is one constant method for the disposition of urban refuse. When the fever-saturated garments of patients suffering from contagious disorders have passed through a baptism of fire, the ashes will convey no morbid substance to infect any one with disease, or when a hospital has its walls filled full with the emanations from numbers of cases of zymotic ailments, and supersaturated to an extent that they return germs of virulent action to the already infected air-buildings that should have inscribed over the door way, "All ye who enter here, leave hope behind." Such hospitals as there are records of, where case after case succumbs to the invasion of erysipelas, puerperal fever and similar disorders, with almost a uniform regularity to such buildings, the purification by fire is a heaven-sent blessing to the community. If three or four years ago, in as well regulated a hospital as our own, it was deemed necessary by the religious bureau to emblazon and decorate the operating room with the motto "Pre-

pare to meet thy God," what motto, then, would they consider equal to the emergency for such a place as that?

Oxygen in moderate quantity is generally needed for the putrefactive condition. Certain forms of bacteria will thrive, if oxygen is present in the culture fluids to a limited extent, while other forms will cease to exist in oxygen, and for a general rule an excess of oxygen will disinfect. Therefore, substances that will supply oxygen in their chemical transformation become good disinfectants. Ozone generators have a good effect in this direction. Permanganate of potassium, iron compounds, "chlorine and bromine, or substances which can be made to supply chlorine, as chloride of lime, which by combining with the hydrogen of water or of the organic material, sets oxygen free."

According to Waller there is also a chemical action besides this liberating of oxygen, imperfectly understood in connection with the coagulation of the albumen of nitrogenous substances. The oxygen is Nature's fire. It burns up, more or less rapidly, the materials on which it acts, but in addition to this method there is the chemical change of the albumen.

Nitrogenous matter putrefying is more dangerous than purely vegetable, the difference in the soils furnishing more or less suitable nutrition for the bacterial germs, and the culture soils containing nitrogenous compounds are better adapted to the development of these special germs of disease which most readily invade the human organism. Therefore, a chemical which expends a force upon the nitrogenous matter, coagulating its albumen, demands attention as a valuable disinfectant. This class of agents includes "the phenols, mineral acids and metallic salts." If our knowledge of disease germs was more complete, and we had the natural history of each special form accurately mapped out, the choice of a disinfectant for the destruction of any germ, or all of them, in fact, would be a very easy matter. Our knowledge, however, is as yet quite imperfect, and the application of the antiseptics and disinfectants must be to a large extent theoretical or empirical, the result of observation of effect.

The effect of heat has been tested sufficiently to show in

what manner it must be applied to destroy the bacteria of putrefaction. The spores are almost indestructible. In the condition of bacteria they are easily destroyed, and heating any matter for a number of times will develop the spores into active life, and destroy them. Theoretically, then, disease germs may be destroyed by heat, and it is very probable that some of them may be extirpated more easily than the putrefactive germs. Vaccine matter, as demonstrated by Dr. Henry, of Manchester, "lost its power if heated to 140° Fahrenheit for three hours." Dr. Henry disinfected scarlet fever clothing by exposure to a dry heat of 212° Fahrenheit for one hour. Woolen clothing from plague patients after being heated twenty-four hours from 144° to 167° Fahrenheit was worn by fifty-six healthy persons with impunity for fourteen days." In Great Britain a dry heat is largely used as a means of disinfection of the contagious diseases. The clothing and bedding are placed in an oven or hot-air chamber, and the temperature is raised to 230° to 300°, and exposed to this heat for several hours, during which they lose the dangerous substances. In some of the ovens sulphurous gas is used in combination with the heat; in others steam is passed through the fabrics that are being disinfected. Of course the character of the stuff that is to be purified, determines the sort of treatment it shall receive, and all clothing must necessarily be somewhat deteriorated by the process. The dry heat is somewhat better than boiling, but when boiling is used some chemical may also be applied to advantage.

"Chloride of lime is often employed in the proportion of one gallon of the strong commercial solution to twenty or thirty gallons of water" (Parkes), or carbolic acid, one part of the pure acid to 100 of water. The German military rule is to place the clothing in a solution of sulphate of zinc, in the proportion of one part to 120, or of chloride of zinc, in the proportion of one part to 240, and then to be washed with soap and water, unless the clothes can be baked. The Chicago Board of Health uses sulphate of zinc one and one-half pounds, common salt three-quarters of a pound, and water six gallons. Into this mixture the clothing is dipped, and



after a short period of soaking it is to be boiled and dried by heat.

As a means of disinfecting such articles as cannot be subjected to this treatment without injury, exposure to the fumes of various substances has been used. The methods of purification of the air of a habitation are many. Bad air may be materially modified by dilution. As a corrosive acid may be taken into the stomach with impunity, if sufficiently diluted, so noxious elements in the atmosphere become easily resisted and overcome by dilution. The strong winds which sweep through the casements of our houses carry away with them, in this process of dilution, much of objectionable matter. Thorough ventilation is a disinfectant in a broad sense of the term, but chemical agencies may be made available when sufficient time cannot be allowed for this, or the concentration of the contagion of the diseases, renders a more rapid and complete destruction of disease germs desirable. The most ready method is the introduction of diffusible gases, chlorine, sulphurous, nitrous, hydrochloric or carbolic acid, fumes of iodine or bromine, tar fumes, ozone. etc. Ozone may be generated in a room by gradually mixing in a saucer three parts of strong sulphuric acid with two parts of permanganate of potash. "Nitrous fumes may be obtained by dilution of the commercial nitric acid with three or four times its bulk of water, and adding to the dilution iron scraps or zinc or copper turnings. Use twice as much of the commercial acid as metal. In the course of a short time the mass froths up and the action is extremely energetic, considerable heat being generated. After the evolution of the fumes, the remaining liquid is useful as a disinfectant, though the metal should be added until the acid is neutralized. This vapor, although very irritating to the lungs, and indeed not without danger if inhaled, has a remarkably powerful effect in removing the odor of a dissecting room, or of the dead-house, accomplishing this more promptly than any other gas.

Chlorine, iodine and bromine are powerful disinfectants, arresting putrefaction promptly, but in common with other gaseous disinfectants, they are very irritating to the lungs.

The most common source of chlorine gas is the chloride of lime, either in combination with an acid or without. It may be placed in gutters, sewers, cellars, etc., and the chlorine will be discharged slowly. Bromine was highly recommended by Dr. Von Tagen, formerly a lecturer in this college, as having a specific effect as a disinfectant in hospital gangrene, and it was used to a considerable extent in the army hospital during the late war. Bromine is so volatile that it permeates an apartment with great readiness. Iodine can also be easily diffused by pouring it on a heated plate, but condenses readily again, so is not as diffusible as chlorine or bromine, but is more pleasant in odor. It may be well to add here that the inhalation of alcoholic vapor will relieve the choking that comes from an incautious inhalation of these fumes.

A solution of the chloride of lime I use for disinfecting purposes after child-birth, or miscarriage, and prefer it to anything else that I have tried: Take a quart fruit jar, put therein one-quarter pound chloride of lime, and fill the jar with water. Let it stand three hours before using. Take one to two tablespoonfuls of the clear liquid, and strain it through a cloth to free it from any particles of lime that may be floating in it. Use this clear liquid in a pint or more of hot water as a vaginal injection, two or three times per day, and the patient will give the report, if the injection is properly given, that the effect was to rest her and make her feel much more comfortable. If the solution with two tablespoonfuls is too strong, use it in a lesser amount. If too strong the patient will complain of smarting and soreness, but this need not happen. Sulphurous acid is one of the oldest and best known of the aerial disinfectants. It is, in my view, the best one of them all for general use.

As sulphur is a king in the pharmacopœia, so also in its sphere in this direction it occupies an elevated place. It coagulates albumen, destroying the destructive elements of the animal putrefaction, and also many of the germs of infective disease. It destroys sulphureted hydrogen, and neutralizes ammonia. Its fumes are strongly irritating to the respiratory organs, and are inimical to life. The inhalation of the vapor

from an ordinary sulphur match will speedily convince the most skeptical of the disagreeable sensation induced thereby. It is very easily diffusible through a room, and is inexpensive and very powerful. The method of use, as recommended by the Board of Health of Chicago, is as follows: Have all the windows, fire-places, flues, key-holes, doors and other openings securely closed by strips or sheets of paper pasted over them; then place on the hearth or stove, or on bricks set in a washtub containing an inch or two of water, an iron vessel of live coals, upon which throw three or four pounds of sulphur. A coal-hod half full of ashes, in which are laid live coals, answers admirably for the purpose. Previous to your placing the sulphur on the coals see "that all articles in the room, and others of every description that have been exposed to infection, which cannot be washed or exposed to a dry heat, and are too valuable to be burned, are spread out on chairs or racks; mattresses or spring-beds set up so as to have both surfaces exposed; window shades and curtains laid out full length, and every effort made to secure a thorough exposure to the sulphurous fumes. The room should then be kept tightly closed for twenty-four hours; then open up the room and expose the contents to the open air. If this is repeated you will make a thorough operation of it, and will destroy all germs of contagious diseases so far as I know.

After small-pox, diphtheria, scarlet fever, etc., this is invaluable. During the course of a severe attack of diphtheria a purification of the apartment by this means, once in two days at least, is desirable. Do not keep your patient in the room while fumigating it, as I once saw it done. Of course the room need not be closed for so long a period if you are fumigating frequently, as the object is not to destroy every solitary germ, but to lessen the number, and to interfere with their vitality. If the air in the room is not damp, no injury will result to the hangings. Of course you would remove all living objects, such as plants, birds, etc.

Carbolic acid is a very commonly used disinfectant, but in my opinion a very much overrated one. Its congener,

salicylic acid, when first introduced, was lauded to the skies as a preventive of putrefaction and a destroyer of fungous growths. I had a strong solution of it, which remained for some weeks in a quiet place undisturbed, and I must confess I lost confidence in its power to destroy fungi when I saw floating in the center of the vial a mass of fungous vegetation of the size of a quarter of a dollar, drawing its nutrition from the very substance warranted to kill it.

The carbolic acid is chiefly of value as an antiseptic, and not so much as a disinfectant, and its continual contact with the substance seems to be required to continue the effect. The salicylic acid has a reputation among wine merchants as an antiferment, but is overrated in that particular.

The metallic salts are used for the disinfection of liquids of a dangerous character. As aerial disinfectants they are of no value. For use in large quantities in the drains and cesspools, in sewers and in stagnating pools under buildings, or in cellars, these are needed. Of the iron salts the copperas solution is the most common. The board-of-health proportion is in proportion of one and one-half pounds of copperas to one gallon of water. A convenient method of preparing this is to suspend a basket containing about sixty pounds of copperas in a barrel of water. The solution should be used frequently and liberally in cellars, privies, water-closets, gutters, cesspools, yards and stables. The cheapness of this mixture is one great recommendation for it and its actual value as a disinfectant is great also. Zinc sulphate and chloride are used for the same purpose. The nitrate of lead will deodorize a cesspool, and may be used at one time, and some of the others at another. It is prepared by dissolving one pound of litharge in about seven ounces of strong nitric acid and two gallons of water. A little of the water is mixed with the litharge, the acid is gradually added, and then the rest of the water. This amount will deodorize a moderate sized cesspool. The zinc disinfectant is sulphate of zinc, one and one-half pounds; common salt, three-quarters of a pound; water, six gallons. Sometimes the zinc chloride is used in combination with chloride of lime in disinfection. The chlorine is liber-

ated in the air, while the zinc remains in the liquid pool to render inert the organisms contained therein.

Thymol is a good disinfectant for the sick room, and to many has an agreeable odor, certainly much more so than carbolic acid or chloride of lime. It is prepared by adding one tablespoonful of spirits of thymol to half a gallon of water. Spirits of thymol is composed of thymol, one ounce; alcohol absolute, three ounces.

Chemistry can do much to counteract the carelessness and negligence of the community, but the maintenance of the sources of pestilential hot-beds will make itself felt in the community. Where the disinfectants are not frequently used the germs multiply, and the removal of offending substances is the first thing for you to insist upon. Bayles tells of a "very practical country physician who was once asked by a neighbor, who was not over particular as to the condition of his premises, what would be the best disinfectant to get for use before hot weather came on. 'I will give you a prescription if you will get it filled, and use it,' said the Doctor. This was agreed to, and the Doctor wrote as follows:

R  
 Rake..... 1  
 Shovel..... 1  
 Wheelbarrow..... 1

Sig. Use vigorously every twenty-four hours until relieved. The hint was taken and the premises cleared up. Sunshine did the rest."

## Clinical Society Transactions.

### THE AUGUST MEETING.

(Continued from page 278.)

DISCUSSION ON THE USE OF HOT WATER TOPICALLY IN UTERINE AND OVARIAN DISEASE.—Our notes of the discussion following the reading of Dr. Ludlam's paper on the above subject (page 246) were crowded out of the last issue of the CLINIQUE, and are therefore given herewith.

DR. S. LEAVITT said that the thanks of the society were due Dr. Ludlam for so excellent a paper on so practical a subject. He regarded it as a most valuable addition to our literature. In a number of the conditions cited he had used hot water with good effect. Among these was pelvic cellulitis. In a recent case he had seen the trouble brought to resolution with unusual rapidity by frequent use of the hot sitz-bath. Dr. Ludlam mentioned in his paper a temperature of water, for vaginal use, of 110° F. In Dr. Leavitt's opinion hot water, when used for its hæmostatic effect, should have a temperature of 120° to 122° F. This would seem scalding hot, but it would not injure the mucous surfaces, and patients of any mental fortitude can easily bear it. When hot water of a much lower temperature is employed the hæmorrhage may be increased rather than diminished by it.

DR. A. K. CRAWFORD had been so much interested in the question of heat as a remedial agent that he spent a whole evening, during the recent session of the American Institute, in looking at appliances for injections, etc. He was satisfied that diseased parts can withstand a greater degree of heat without injury than the normal tissues can. For this reason he had been especially interested in the instrument devised and advised by his friend, Dr. L. R. Palmer, which consists of a double canula and an insulated tube, through which water at a temperature of 140° or more can be safely applied

to any particular part or point of the uterine or vaginal surface.

DR. E. S. BAILEY.—I am pleased to have heard this report, and can heartily indorse it from beginning to end. For some years I have known hot water to be a powerful therapeutic agent. I feel like referring to that portion of the report which recommends care and discrimination in its use. The more I know of its virtues the more particular I am in recommending it, and intelligently applied it seldom fails to give most excellent results.

According to the experiments of R. Milne Murray, "the action of hot water seems to be largely concentrated upon the blood-vessels, although doubtless succulency is increased by osmosis." He also says: \*

"1. Water at temperatures of 120° F., and 10° lower, constricts blood-vessels and arrests hæmorrhage from small arteries.

"2. Water at temperatures of 100° F., and 30° or 40° under, dilates small vessels and promotes hæmorrhage.

"3. Water at temperatures of 50° Fahrenheit and 20° under checks hemorrhage by constricting the blood-vessels, but this is only temporary.

"4. After water at the above temperature has lost its styptic power, water at high temperatures is still effective."

Poisenille's experiments are confirmatory where he says: "Ice in a short time causes the circulation in the capillaries to cease altogether, but on its removal in a few moments, the circulation is restored, while on the other hand water at 104° Fahrenheit, increases the rapidity of the circulation, and also causes the arteries and capillaries to be distended. Water to be effective as an agent to control the circulation and limit inflammation, must have a temperature of 105° and more."

The fact must also be kept in mind that when the blood-vessels have been dilated, as in the first stages of inflammation, the rapidity of the circulation becomes progressively diminished until oscillation of the blood in the vessels takes

\* On some of the Physiological and Therapeutic Effects of Water at Different Temperatures, with special reference to Obstetric and Gynecological Practice.—*Edinburgh Medical Journal*, September, 1886, page 221.

face, which occurs when the circulation is about to cease. Sometimes complete stasis happens.

In limiting the discussion to diseases of the female pelvic organs, one important factor must not be overlooked. The productive organs are exceedingly rich in blood-vessels, not much in the large arteries and veins, but in the numberless capillaries. In general the capacity of the capillaries exceeds that of the arteries by 500 to 800 times. When the pelvic viscera are in a state of inflammation the blood-vessels are dilated, overdistended, engorged, and an enormous amount of blood is held in the parts. With this engorgement of the entire capillary system, the conditions of redness, dryness, and pain are very marked. According to the experiments referred to, water at 105° will not change the condition of the now interrupted circulation. It would rather tend to perpetuate or still further embarrass it.

There are most excellent reasons for the author of this paper insisting that the water shall be used hot. The familiar illustration of the wrinkled and whitened condition of the washwoman's hands in consequence of constant submergency in hot water, may give us a little understanding of how the hot water acts, and also continues to act. The first stage is to increase the amount of blood in the parts, causing increased redness, etc. the continued application, however, pinches out the blood, and reduces the size, and changes the contours. It is likewise possible that these currents of hot water administered as directed, and repeated as judgment and experience suggest, pinches out and propels the blood from the overdistended capillaries, and through the regulation of the circulation, affords the patient ease, and limits the bad results of the inflammation.

By way of caution, in the chronic cases where a sub-acute inflammation may suddenly become acute from cause, a too rapid or too vigorous exhibition of very hot water will bring about a sudden reaction and shock. Twice this has been my experience, one of the patients falling into a condition of collapse.

The oft-repeated and long continued use of hot water,



administered by the patient herself, in nearly all of the ways mentioned in the paper, for the relief of a chronic pelvi-peritonitis, resulted, in my belief, in a functional disturbance of the heart, and also an almost complete surrender of the pelvic disease. Some patients are actually intolerant of hot water, but can endure and even welcome very cold water. Some are able to use water extremely hot. In either case a caution is necessary.

DR. H. P. SKILES was of opinion that, a great deal depended upon the position of the patient. What it should be when these injections are given is a very important question. He did not come in season to hear the reading of the whole of the paper, and therefore did not know if that point had been touched upon. In regard to intra-uterine injections he would like to know about the quantity of water that is proper to be used. He was satisfied that pain and collapse sometimes follow the use of these injections, especially if the water is discharged from the end and not exclusively from the sides of the nozzle of the syringe.

MRS. DR. C. T. CANFIELD expressed herself as having been very much interested in the paper just read. It was profitable and practical to have such special essays brought to the Society, if only that the scattered results of experience, and the reliable indications for the employment of such valuable agents were collected and made available. One hint contained in the essay was new to her, and that was the use of warm or hot water preparatory to placing the uterus in position, where the organ was badly, and chronically displaced. She should certainly try that expedient in the future, and had no doubt of its efficacy.

DR. LEAVITT said that Dr. Skiles was quite right in attaching some importance to the non-presence of an opening in the end of the nozzle used for the vaginal douche; but he regarded its absence a matter of moment only in cases of uterine retroversion. When the womb is in its normal position, the nozzle of the syringe is introduced at almost a right angle to the long axis of the uterus, and the stream from an opening in the extremity of the tube would not directly enter

the organ. When the uterus is at an angle the converse of normal, as in retroversion, the line of vaginal introduction, and the long uterine axis nearly coincide, and an end opening result in intra-uterine injection, and consequent colic. He thought there was a difference between warm water and very hot water in the effect on capillary circulation. Hot water primarily contracts, and warm water primarily relaxes, the vessels. The immediate effects on the blood vessels of very cold and of very hot water, is pretty nearly the same, though the indications for use may widely differ.

DR. W. S. GEE.—The paper presented to us by Dr. Ludlam is a very practical one, and I wish to express my appreciation of the fact that a great good will result from this successful attempt to arrange and systematize facts, some of which have been recognized in a general way. It is proper that it should go into our literature, for it is at once authoritative and will be to the credit of our school.

The outlines here indicated for the use of hot water almost amount to the dignity of a proving, and in this way it will prove of service to the young physician before he has learned the real sphere of it by actual experience. It is pleasing to note that the author of the paper does not state that it should be used in *all* cases. It is a fact that we meet patients whose symptoms are aggravated by the use of this valuable remedy. Nervous, dwarfish, little women will sometimes say, "I am so weak after using the hot water, and I feel worse." Then some other form of its use might be tried, or study the case anew with these new peculiar symptoms, and select the remedy. If we were to persist in the use, after learning these new facts, the congested ovary might not be relieved short of an abscess; or the tumor in the pelvis, which is the result of effusion and would otherwise disappear by resolution, might change into pus, and a more serious complication result. Just in proportion as a remedy will prove curative when properly given, is it likely to prove harmful when wrongly used.

DR. LUDLAM, in closing the discussion, thanked the members present for their evident interest in his report. As practitioners we all know the occasional need of adjuvants of one

kind or another. The difficulty is in selecting such of them as will neither interfere with nor antagonize the action of properly chosen internal remedies. The object of the paper was to indicate the scope of warm and hot water in gynecological practice, more especially because the literature of the subject is scattered, and not available to the members of this Society, or to the profession at large. He was aware that water at a higher temperature than 115°, the highest figure given in his paper, could be used, not only with impunity, but with the best results, but it is not often necessary to have it above 115°. Dr. Palmer's instrument furnishes an excellent method of employing *heat*, but not of hot water, for it altogether excludes the moisture.

The caution given by Dr. Bailey is wholesome, and the explanation of his peculiar experience lies either in the idiosyncrasy of the patient, or in the possibility of utero-cardiac complication which, in chronic cases of pelvic inflammation and abscess, we ought always to look for, just as we remember the probable co-existence of heart disease with old renal affections. Many a poor woman who is the victim of the uterine dyscrasia suffers also from an "irritable heart" that is not unlike the form of it first described by Dr. Alfred Stille as observed in the case of soldiers. In such cases the hot vaginal douche might readily work mischief as an indirect irritant, without causing any decided revulsion of blood to the heart.

He was satisfied of the positive efficacy of hot water when intelligently used, and he was also satisfied that in some cases it had a negative merit that had not been alluded to in the paper. We may sometimes take advantage of this where there is a needless demand that will not be satisfied without some kind of local treatment. These are the cases referred to by old Dr. Watts, when he says:

"For Satan finds some mischief still  
For idle hands to do."

## THE SEPTEMBER MEETING.

NERVE PROSTRATION AND REST.—By H. B. FELLOWS, M. D.—

Two detrimental elements enter into modern life: *Hurry* and *worry*. Both are given intensity by the prime promoters of civilization, and in just so far as the enlarged uses of steam and electricity have revolutionized our daily lives, enabling us to live more and live faster in a given time, so far have the consequent and inevitable hurry and worry been registered upon our nervous systems. If for several generations the life has been lived at this high pressure, we find heredity adding its force to the baleful influence, and a hypersensitive nervous system as the result. True, ancestors may have shown little or nothing of hypersensitiveness, but if the inheritance be *toward* hypersensitiveness the nervous system, under the slightest provocation, becomes disordered.

Hypersensitiveness, and the consequent weakened nerves, is by no means wholly a modern ailment, though probably, at least in this country, more common to-day. Indeed, so long as we live the artificial lives that most of us do—*a fortiori* if we resort to even greater artificiality—this nerve-weakness will surely increase.

Useless then, and most reprehensible, is it for the man or woman whose nerves, strong by birth, are as yet undamaged by hurry for money or worry for bread, to pooh-pooh this weakness of the nerves. How often is the advice—wise but in the egotism of the giver—offered the sufferer: “Don’t let your nerves get the best of you. Hold them down. Don’t think about yourself.” How often is the sufferer told that if he would work hard during the day he would be tired enough to sleep at night! How often does such advice come from physicians! In a case under my observation, of insomnia complicated by other nervous symptoms, the man had been advised to take a long, brisk walk just before retiring in order to get the blood out of his brain, and this notwithstanding that he was obliged, while overlooking his business, to go daily many times over a building of several stories, with the attendant stair-climbing, besides attending to all the more

perplexing questions on the commercial side of his business. It is needless to say that he grew worse under the treatment. To add further fatigue, even though only of the lower nerve centres of the leg, to the exhaustion already present, was to insure, not sound and refreshing sleep, but an increase of insomnia and nervousness, to a point at which the system must become a wreck. In this patient it was the hurry to be rich that had prostrated a naturally vigorous nervous system.

Very general is the belief among laymen—a belief not as yet entirely eradicated in the medical profession—that because there is no visible physical lesion in nervous patients, therefore their sufferings are unreal, and but children of a diseased imagination. Constantly do we hear said of such sufferers: They could do so and so, as well people do, if they would only use their reason and will power; or, at least, they are credited with being hysterical—that convenient pigeon-hole into which are so often thrust moans and complaints which attendants are too busy or too ignorant to investigate—and, it is said, the patient should be given some “plain talk” and compelled to go about his business as other people do. Not seldom will some one—of abundant zeal even if lacking in good sense—shall I add, it is sometimes a doctor?—tell the sufferer that he has no disease, and it is nonsense, or worse, for him to call himself an invalid, or claim the invalid’s privilege. How many of the victims of such “plain talk” have been silenced—*silenced*, but not convinced! Are they cured? Verily, not. Their complaints, it may well be, are no longer carried to the cruel and ignorant adviser, but they are simply transferred to some more sympathetic ear, or, with the wounded feeling that like a newly sharpened blade touches the hypersensitive nerves, are suppressed and crowded back into the secret chambers of the heart. Just the same does the suffering remain; not one pain—not one jot or tittle of nervous exhaustion—not one weary hour of insomnia the less.

Probably such patients do exaggerate their symptoms and suffering, but is not that natural, so long as both are unrecognized? Besides, does not everything act with greater force

on irritable nerves, and the same circumstances affect very differently nerves and mind in the nervous and in the robust? And if the symptoms are painted very black, is not that part and parcel of the diseased condition itself? Do you adopt a similar philosophy when called to a case of delirium tremens, insisting that the "blue devils" are all nonsense, expecting the patient to accept your view, and sleep quietly? True, when well again, he will need no argument to convince him they were but the figments of a disordered brain.

A person may be stark mad, and yet there be no visible change in the tissues of the brain. No one conversant with insanity would on that account doubt that the person was a fit subject for medical treatment. But a fond mother once grew very irritated because I told her that her "plain talk" would not cure her son of delusions, and restore him to mental health. Nervous irritability may be compared to insanity—the condition of the nerves in the one corresponding to the condition of the brain in the other—and a weak nerve may exaggerate, or modify, or entirely change, the result of a normal stimulation, in like manner as the mad brain distorts the life in all its varied relations. Thus, a word, a look, a gesture astray, may rob a night of its sleep, and unloose the dragons of restlessness and pain. Often will the physical suffering react on the brain, until the mental condition becomes as pitiable as the physical. Last spring I saw a lady, of nervous temperament, and in past years a sufferer from nervous weakness, who, during treatment by the rest-cure, carried out on the Weir Mitchell plan, became so affected by her masseuse as to have a horror of her presence, the mind at last becoming so affected that the lady said herself—and was confirmed by her husband—that she was "a little off." This did not result from any especial harshness on the part of the masseuse, but she was personally disagreeable to the patient, whose hypersensitive nerves were at last so wrought upon that "rest" was out of the question. This baleful influence of the rubber in the rest-cure, as systematized by Mitchell in this country and Playfair in England, has been recognized by the latter, inasmuch as he changes the rubber if the good effects expected are not soon visible.

Last winter an old and valued patient of mine, one whom I have known for years, and who had in more than one trying situation exhibited a strong character, and one thoroughly balanced, suffered from great nervous weakness and from insomnia. Her *bete noir* was one of her servant girls, whose very presence would unnerve the lady for hours afterward, murdering sleep until the "wee sma' hours," when she would sink into the troubled slumber of exhaustion. The nervous condition was the result, no doubt, of many months of deep anxiety concerning the health, and even the life, of her husband. I could find no trace of organic disease, yet no one who had known her in the past could doubt her unfortunate condition then. If any cases there be which can be cured by "reasoning" and "plain talk" this was surely one. Such was not the plan adopted, however. The nervous sensations were accepted as realities, and a course of treatment pursued that gave rest, and consequently strength, to the nervous centres, with the result that a most useful life was restored to its well-nigh lost usefulness.

Again, we have the numerous cases in which the patient, bed-ridden for months or years, has been made to take up his bed and walk, through the reputed agency of prayer, the faith cure, the so-called magnetic doctor, etc., etc., and which, to the superficial thinker, do lend a support to the theory of the all-sufficiency of will power or supernatural agency as a cure for nervous diseases. But deeper reflection at once suggests that the circumstances of force which usher in victory—the command to rise up and walk—the convulsion of terror at impending danger—do but influence the patient to *try* to walk, while the *ability* to exert himself is in fact rooted in a protracted and perhaps bed-ridden rest, in which the struggling and worrying for health have ceased, and during which the nerve centres have regained their normal strength. Often, too, has the rest been accompanied and deepened by an acceptance of the idea that a return to health was no longer to be hoped, but that rest remained—the sole boon life had now to offer. The muscular weakness that remains after the nervous centres have recuperated their strength is, ordinarily, easi-

ly removed by the simple exercise of the muscles. Yet, if the experiment be tried too early the patient, though doing so much as to surprise all his friends, is very prone to relapses, and his latter end will then be worse than the first. Rest is here the potent element in the cure, and all the mental influences not in harmony with it, and which do not add force to it, but delay the cure or thwart it utterly. How worthless and meaningless, then, the eclat too often won by the "new doctor" and his Force cult—whether he be a graduate of a medical school or but a Christian scientist—seeing he was but as one "in at the death" of game that others had chased and killed.

It is not always the case that nervous persons are great sufferers in the beginning. A local nervous weakness may develop first, and for some time leave the general nervous system in a comparatively normal condition; for example, certain digestive difficulties may constitute the first links in the chain of symptoms, and sensations of fullness and eructations, feelings of sinking about the stomach, or even nausea and vomiting may succeed the meals. It will be found that these symptoms are nearly always subject to being influenced by the mental condition, and that unpleasant excitement, or a bit of bad news, will aggravate them to a pitch beyond the control of the will power. Where the will is strong they may be fought off for some time, but they will return again and again, until they extend to other nervous centres, and may, finally, involve the brain itself. A stomach thus weakened, even after having been on its good behavior for some time, may, if the person undergo excessive fatigue or if he be subjected to worry, redevelop all the old symptoms at any time. What shall be done in these cases? Shall we advise that the stomach be not consulted, and that it be forced to its work by the eating of more highly seasoned food—that the bad feelings in the epigastrium be suppressed by ignoring them? The brain, if exceptionally strong, will sometimes gain the mastery for a time, but is more likely to respond by a severe headache. It is said to be a very common thing for those who go down to the sea in ships, and who are able to control their nausea arbitrarily, to suffer from severe pain in the head.



For this local nerve weakness there is one especial remedy: a rest sufficiently prolonged to give the implicated nerves a chance to recover something of their original strength. I have no doubt that if persons with weak stomachs would lie down for an hour, or even for half an hour, after their mid-day lunch they would find that their afternoon work would be more easily turned off, and that their stomachs would soon cease to exhibit the ingratitude of dyspepsia.

What shall we consider the underlying cause of nerve prostration? It may be summed up in the one phrase—*nervous agitation*. In all of our lives, however well ordered, some causes of agitation must be present. When these causes multiply themselves, acting on a nervous system, inclined, by hereditary influence or by artificial living, to hypersensitiveness, nervous prostration will result. If the foregoing premises are correct, the conclusion that follows must be true: that the prevention and cure of nervousness have for a basis, rest.

For the man of nervous constitution rest must be his means of avoiding the danger that lies before him. When fatigued to the point of exhaustion, it is not good philosophy for him to rise early that he may make the most of the day; rather should he lie an hour later, taking a holiday as often as possible, even taking his holiday in bed if thus he can escape the strain to which his hurry and worry are subjecting the nerves. Should nervous prostration be already upon him, nerve rest will be an absolute necessity of his recovery. Many methods of rest are available, all having their adjuncts, which I by no means deprecate.

In all cases, however, we must seek as complete nerve rest as possible, and this implies the maintenance of agreeable sensations and the avoidance of nervous agitation. Such ideal rest may be an impossibility, but it must be the aim. Some may reach it by a trip through the mountains, being none the worse for the climbing; and for others such a trip would be worse than folly. The criterion is, whether the exercise of the day brings more than a muscular fatigue which can be slept off at night. Some will find their Eden in lounging on the deck of

a steamer; some will find it in watching the blue waves on the sea-shore change their tints as the sun mounts apace and the tide runs in and out. But if sufficient exercise cannot be taken to keep the muscular system in good tone, so that it shall have a proper reaction on the nerves, a daily treatment of massage may be instituted with benefit.

*Discussion.*—DR. A. K. CRAWFORD.—It would be difficult to throw more light upon so clear a paper. I do not believe that the Weir-Mitchell plan of treatment is the best for all our nervous patients. If you can find some kind of voluntary exercise that is congenial, and that includes out-of-door exposure, it will be most useful in many of these cases. The muscular system must be brought into play by some light employment, as in gardening, for instance, in a suitable climate.

DR. J. D. CRAIG believed that the necessity for rest in most nervous disorders cannot be too strongly emphasized. But rest does not mean idleness and inertia; it means a change of occupation and of the patient's surroundings. He must have something to do and something to think of. It involves the principle of mental and bodily diversion, which is a very different thing from stagnation.

Another point is that in prescribing rest for our patients when they need it, as so many of them do, we do not always remember that with quite a share of them it is impossible for them to quit work and go away. They are tied to a routine of drudgery which they must not leave, and they have not the means with which to travel. It is household drudgery that is killing half the women, and they are the ones who need the "rest."

DR. ARNULPHY—In corroboration of Drs. Fellows' and Craig's statements, I would say that the word *rest*, as applied to nervous disturbances, widely differs from the habitual idea of a mere cessation of activity. I shall cite one instance that is calculated to convey the exact meaning of the point at issue. It is a well-known fact among those to whom small details in the life of great men afford some interest, that

Buckle, the author of the "History of Civilization," used to find marked relief from higher and weightier pursuits in the game of chess, wherein he soon became a master. Now, anyone who is even slightly acquainted with the intricacies of that game, knows that this meant no inconsiderable display of imaginative and combinative power. Still it was positive rest for him. It seemed to switch the energies of his brain onto an altogether different track, one, at least, that gave him pleasure and afforded, as it were, a change of air and landscape to his thinking cells.

I would also call attention to another order of facts. I refer to the more or less permanent or pronounced disturbances of function, and possibly alterations of tissue likewise, in the intestinal tract, that can be met with as a sequel of protracted neurasthenia. There is reason to surmise that in some obscure cases a parietic condition of the muscular coat of the intestines may be brought about, attended with symptoms of gradual dilatation and accumulation of fecal matter, and all the consequences thereof, so as to simulate a stricture.

DR. R. LUDLAM—The paper just read is very practical and suggestive; for surely if there is one condition which more than almost any other needs a close and careful discrimination as to its cause and the choice of a remedy it is the "nervous prostration" of which Dr. Fellows has spoken. It springs from so many sources and has so many symptoms that no one remedy, or class of remedies, will suit all cases. And what is true of our medicines is also true of rest as a means of relief. Its kind, degree, attenuation, dose and repetition are of the utmost importance. There can be no doubt that as it is usually prescribed, without care and judgment, it often does more harm than good.

There is the same difference between resting and loafing that there is between changing the bearings of a piece of machinery so as to keep it in motion, and allowing it to stand idle and become rusty. The Weir-Mitchell rest-cure is especially adapted to the two classes of patients for which it was originally designed, *id. est*, to those who are fat and those

who are anæmic, and who at the same time are the victims of nervous prostration."

In some of these cases it is no small thing to economize the patient's strength by slowing the heart from ten to twenty beats per minute; and this can be done by sending them to bed and keeping them there. A lack of exercise under these conditions can be compensated by careful massage. The strength is also saved by stopping the waste of muscular tissue, which, while it continues under too active exertion, increases the quantity of urea that the kidneys must eliminate, and the retention of which is such a mischievous factor in nervous affections. Under a proper system of rest the kidneys not only do their work more thoroughly, but it has been found that they actually excrete a larger relative quantity of urea than under the opposite condition.

Dr. Fellows has underscored the importance of removing the slight and apparently trivial causes of nervous worry and irritation, in order that the best effects of rest and change may be realized. There is practical force and good sense in his idea, and it often requires more tact and skill to find the thorn in the flesh and to remove it, with or without the patient's knowledge, than to arrange for the special means of rest and diversion afterward.

There is one peculiar source of nervous irritation of which I have seen nothing in our books and journals, and I may, perhaps, give offence by mentioning it, but no matter. I allude to the over-zealous care and the consequent antagonism that naturally exists between so many mothers and their daughters, and which is often in the way of recovery. The members of this Society must have observed that, as a rule, in case either of them is ill, the daughter makes a better nurse than the mother; in other words, if the daughter takes care of the mother there is less jar, and her solicitude becomes a grateful tonic instead of an irritant.

Considering how many good mothers there are in the world, it sounds harsh to say that, when the daughter is herself about to become a mother, or is ill with some obstinate nervous affection, she will usually make the best progress if

she is in the care of a nurse who is not of her own family. Who can estimate the mischief that has been done, and with the best of motives, by over-anxious mothers during the labor and the lying-in of their own children! They are not only an annoyance to the doctor and a nuisance to the nurse, but their very presence, strange and wicked as it may seem to say so, is often a drawback and a disadvantage to the patient; for the two parties who are most concerned in the outcome are very apt to be, *volens volens*, at cross purposes. This antagonism and nervous nagging, of which neither the mother nor the daughter may be cognizant, involves a kind of friction that is wasteful and serious. And the worst of it is that, as the accidental lesions of the soft parts leave something for the gynecologist to do farther on, so the nervous and mental disorders that follow, and which should have been averted, are entailed upon the patient.

Outside of the puerperal state this hurtful sympathy, this home ferment, this same peculiar cause has its influence in the origin and the perpetuation of some of the most intractable nervous disorders. In some of these cases, but not in all, there is absolutely no such thing as curing the patient while the mother and daughter live together. They must be separated; somebody must travel; and they must not see each other for a considerable time.

Mrs. Dr. ANDREWS cited a case in which the reverse of this antagonism was true, for the only rest that the patient obtained was through the soothing and quieting influence of her mother.

Dr. LUDLAM replied that there were plenty of such cases, for which we ought always to be grateful. His idea was that in a certain share of nervous affections among women, the difficulty in curing them depends upon an incompatibility of temper, or a species of antagonism between the mother and her daughter. If there were only one case of this kind in a thousand the intelligent physician should be able to recognize it and to treat it accordingly.

Dr. FELLOWS—I am glad that the last speaker has brought up this phase of the general question. It simply illustrates

cases that were mentioned in my paper; for this peculiar agonism of which he speaks arouses the nervous irritability of the subject. Nerve-agitation may be a trifle in itself, but it stirs up this excessive nervous irritability it is a real source of suffering and of disease, and must be gotten rid of before the cure can be effected.

**A CASE OF CONVULSIONS IN A LAD OF TEN YEARS, RESULTING IN DEATH.**—BY N. C. KEMP, M. D.—I was called to see a young lad of ten years on the morning of the 22nd of March last, who, the messenger said, was "in a fit." On arriving at the home of the boy I found him in bed, quiet and comparatively comfortable.

His parents informed me that he had had a convulsion last night some minutes, and, if their report was to be relied upon, had been a very severe one.

As the boy was now quiet I decided to wait and see if there would be a recurrence of what had just taken place. I did not long to wait, before I noticed the eyelids and muscles of the face begin to twitch, and the eyeballs to roll upward and assume a glassy appearance. This twitching and jerking passed downward over first the body, then the upper extremities, and then the lower, until within a few seconds from its first appearance of the twitching he was in a state of complete tonic spasm. The eyes were wide open, balls rolled upward and to the right side, tongue protruded from the open mouth, from which there flowed a liquid very much resembling mucilage in color and consistency, but of this I will speak more fully a little further on.

Although the patient was rigid, he was by no means quiet; partial opisthotonos was present; his breathing was so stertorous that he might be heard anywhere in the adjoining rooms, and every muscular fibre seemed to be wrought up to the utmost tension, bespeaking a profound nervous disturbance.

This condition lasted from three to five minutes, when the muscles relaxed, he became conscious, and was in about the same condition in which I first saw him. The pulse was now 100; the temperature 100.8; the pupils were slightly dilated, though during the spasm they were contracted to mere points.

The convulsions continued to recur in rapid succession, in spite of all the usual remedies and expedients, until he had had six or eight of them, when I gave him chloroform to complete anæsthesia, keeping him there for almost an hour.

When he awoke from the anæsthetic he was quiet, and the nervous storm seemed to have passed over.

The measles were at that time epidemic in the neighborhood, and his parents said that he had just had them, and the day before had gone out for the first time since getting up. No physician had been called in during his attack, hence I was not sure whether he had had the measles or not. They said he had had no untoward symptoms, the eruption had come out well, and that he had really been in bed only two or three days. It was now little more than a week since the beginning of his first illness.

This last attack left him very weak, but in a few days he was up and around the house, but the appetite is poor, he does not rest at night, and he now has constantly what he terms "choking spells," which simulate *globus hystericus*, for he says that something comes up in his throat and chokes him.

At such times he is red in the face, the eyes stand out, and he has the appearance of one who is being choked by something that is lodged in the throat. This spasm of the glottis, as I conceived it to be, would last only a few seconds, after which large quantities of the mucus referred to a moment ago would well up, as it seemed, from the stomach, and pour from the mouth without any effort on the part of the patient. This discharge, at times, would amount to several pints in the twenty-four hours. It was not vomited, nor was he sick at the stomach at such times.

In five weeks after the first he had a second attack, which was controlled as the former had been. The urine now showed ten per cent of albumen, which was persistent to a greater or less degree throughout.

For twelve hours previous to these attacks the urine would be very much lessened in quantity, and sometimes entirely suppressed.

*Apis*, in conjunction with a liberal flaxseed-meal poultice over the region of the kidneys, relieved the suppression at first, but *Cantharis*, *Terebinth*, *Merc. cor.*, *Nux vomica*, *Verat.* and other remedies were given upon indications. Suffice it to say, that, regardless of all treatment, the attacks continued to recur, the third one coming in three weeks after the second, and so they continued to come, increasing in frequency from week to week; but, as they increased in frequency, they became proportionately lighter and of shorter duration, until at the last he had a slight spasm almost every hour of the day.

His diet was now milk principally. Slight general anasarca supervened; he continued to grow weaker, although he did not become emaciated until he died, two weeks ago, or

about five months from the beginning of his first illness. For one month previous to his death a complete paralysis existed on the right side. The right arm and leg were entirely useless, and the face presented the peculiar immobile, expressionless appearance seen in paralysis of the tri-facial nerve.

In the absence of reliable data concerning my patient's first illness, I considered the cause of the last one to have been a suppression of the measles, probably from going out too soon, which set up a nephritis, thus producing uræmia and the neuroses which finally resulted in his death.

III. CLIMATIC TREATMENT OF DISEASE.\*—By A. K. CRAWFORD, M. D., CHICAGO.—It has only been within a few years past that European physicians have been directing their patients, particularly those with pulmonary disease, to seek amidst the Alps for a comfortable winter abode. The place of all others which has been most favored by both the laity and the profession, has been the now quite famed district of Davos.

In the first place it may be asked why send such patients to a cold climate, especially in winter; in the second, what are the particular qualities of this chosen region that has gained for it such good repute; and third, what have we in America that possesses similar physical conditions, and which will answer the same end?

It is a long since exploded idea, that the tropical countries were the most exempt from tubercular diseases, and it needed but little argument to condemn the same as curative resorts for those already afflicted. The enervating influence of excessive heat was readily acknowledged to be direful in its effects upon these patients whose one great, common heritage was debility. But it took time and the test of practical experience to arrive at the conclusion that a dry, clear, frosty air was especially salutary to European consumptives.

I say, to European consumptives, because, so far as I am aware, there has been no such methodical, clearly defined, and successful plan of procedure carried out by the physicians of this country as has been done in Europe. As long ago as 1840, Dr. George Bodington, of Warwickshire, England, ad-

\*Continued from page 277.



vocated "dry, frosty air" for this class of patients. One of his arguments reads: "The cooler the air which passes into the lungs the greater will be the benefit the patient will derive. *Sharp, frosty days in the winter season are most favorable.* The application of cold, pure air to the interior surface of the lungs is the most powerful sedative that can be applied, and does more to promote the healing and closing of cavities and ulcers of the lungs than any other means that can be employed." It was some years later, in 1864, that Dr. Hermann Weber asked for the co-operation of the whole medical profession to examine and decide as to the power of the Alpine winter climate to arrest or ameliorate phthisis.

But the published details of cases benefited or cured by a residence in the Alps dates scarce farther back than the present decade, and thus far we are mostly indebted for these reports to Drs. C. Theodore Williams and A. Tucker Wise, who, with many others, agree upon the decided efficacy of such climatic treatment. They note especially "in persons who have undergone the Alpine cure, unusual expansion of the chest, gain in flesh, and improvement in sanguification."

Now this elevated valley of the Canton des Grisons, in Switzerland, wherein Davos Platz nestles, is a plain about 5,000 feet above sea level, and pretty well surrounded by mountains 9,000 to 10,000 feet high, which guard off the north and west winds, but do not so perfectly guard those from the southeast. Snows fall and lie here with scarce any thaws from October to the following March. There is only a sparse population scattered over the fourteen miles of valley land, and there are several good hostelries for the care and comfort of travelers seeking after health or pleasure, or both. The altitude is an excellent one for consumptives. The snows smother the dirt and reflect a species of warmth from the abundant sunlight; the mountains ward off bleak winds; the 15 to 20 degrees of frost acts beneficially upon a febrile state, stimulates the skin to more normal action, and reduces the tendency to sweats, and this degree of cold, it is claimed, is not felt by patients more than sufficient to suggest slight exercise. In consequence of this splendid combination of

hygienic conditions in the midst of a picturesque country Davos has gained its present popularity. Dr. Wise in his *Alpine Winter* says of it: "The air is as pure as Nature can possibly produce it, clean, dry, calm, and laden with balsamic vapors from the pines."

Many a patient has been shipped off to Colorado, not because the medical adviser wanted to get rid of the responsibility of the case, but on the general principle that mountain air would benefit him. And it has been my lot to see quite a number of these cases return, glad if they might only reach home before death overtook them.

I cannot believe that all of these sick folk were beyond the reach of medical science when they started for the Rockies, but I have always held firmly to the conviction that their location there had not been judiciously chosen.

Neither Denver, Colorado Springs, Manitou, nor Los Vegas, for that matter, are places at all adapted to the requirements of phthisis patients. They in no wise answer the descriptions of the carefully selected spots in the Alps, like the Canton des Grisons, or the Engadine. The Rocky Mountain resorts mentioned are all more or less exposed places on the eastern declivity of the range, and subject the poor pulmonary subject to winds and those wretched insensible draughts of air that suck through the gorges close by. With such a vast aggregation of mountains as exist in Colorado and the adjoining States, it is prerequisite that the physician who advises a patient to betake himself to the hills shall know first something very definite about the physical geography and atmosphere of his patient's destination, and next, something very definite about the physical condition of the case in hand and what he requires.

General principles will not subserve the purpose in climatic treatment of disease any more than they will in the therapeutics of disease.

The Wahsatch and Rocky Mountains present several well defined basins to the climatological hunter. The great central basin of Salt Lake, and that also of the Humboldt

River, are excellent healthful plateaus of medium altitude, 4,000 to 4,500 feet elevation, but do not answer, even approximately, to what we are now looking for, viz., an American Davos. In Colorado can be found spots bearing a much closer likeness. Of the three basins in the Rockies, the North, Middle and South Parks, so called, only the last named is accessible by rail, while the only one of the three which gives promise of being all that could be desired for a mountain-encompassed, high valley health resort is the Middle Park, and this, as yet, is almost as a sealed book. From out the labyrinth of intersecting ranges, which form many an undescribed, sheltered cup that will eventually become the health restoring home of the phthisis patient, I will here name but three. These are Ouray, Glenwood Springs and Aspen. Ouray and Aspen each have an altitude of over 7,500 feet, and Glenwood Springs, 5,200 feet. The latter is practically the same elevation as Davos, and the two former the same as St. Moeitz in the Engadine. All three are most picturesquely located towns of only a few thousand inhabitants, well protected by massive mountains, and consequently possess all the beauties and benefits that can be claimed for the famed Alpine resorts. As it is only very recently that these places have witnessed the *Iron Horse* invade their precincts, the opportunities from this time forth to practically test their healing powers will be very greatly enhanced, and we will soon have reports establishing or contradicting the foregoing theoretical claims. If the pulmonary cases do as well there as their European cousins have done in the Swiss Alps, the question that will be propounded to each new candidate for climatic treatment will be: "Why in the name of the Denver and Rio Grande don't you go to Ouray?"

Still there are plenty of cases, some of phthisis, on whom elevated resorts act perniciously, and others who are not suffering with this disease will find it much to their advantage to remain away. If, for instance, the subject is of an erethistic constitution, or inclined to articular rheumatism, if he is advanced in years and the circulation of the blood is quite poor, if there is well-marked emphysema present, if a tuberculous pleuritis has added empyema to the existing lung trouble, if there is acute inflammation of the throat, or ulceration of the larynx, with pyrexia and rapidly progressing emaciation, or if disease of the heart or of the kidneys complicates the case, do not advise, but peremptorily order such a patient to avoid high altitudes. A medium elevation of, say 3,000 feet, is the utmost limit to which he may be allowed to

go, until, by careful treatment, whatever complication he suffers from has been modified or overcome.

And it should be no less strongly impressed upon our patients who seek high altitude resorts, that they should not rush there pell-mell as fast as a cannon-ball express train can carry them. The journey should be planned in easy stages, each successive stopping-place being at a higher level than the last, and the return from thence should be equally judiciously carried out. When, as is frequently the case, a *summit* must be crossed to reach the haven desired, the reclining posture should be preserved until the descent is made again. A vial of the aromatic spirits of ammonia may be all that will be required by the patient at such a time, for it has been my observation that the dyspnoea experienced by some when a mile and a half or two miles high is from cardiac rather than from pulmonary failure. It is not that there is not plenty of oxygen offered to the blood, even though the pulmonary capacity is much diminished, but that the heart quails, and the blood-current, stagnating in the lungs, as well as throughout the body, fails to pick up the oxygen inspired.

THE LATEST ECHOES ON TUBERCULOSIS.—BY DR. B. S. ARNULPHY.—Until of late the study of tuberculosis has resembled what Byron said of love:

“An idle chase of hopes and fears.”

Tidings now come from Paris of a congress, held there in July last, which would seem to encourage the former without lessening the latter. Not that the congress has discarded the theory of the virulence of the disease, on the contrary, the distinguished host of physicians and veterinarians, who had congregated in the gay capital from the “province” and from most of the countries of the world where the spirit of man is aroused to a proper sense of duty to humankind, had brought such an overwhelming array of facts to its support as to make the most callous sceptic stagger on his feet.

But, if such be the case, we at least have learned to know or suspect where the enemy lies in ambush and where to strike our blows, and there is some consolation in that, as it may in time turn the tide of battle. An imposing areopagus it must have been indeed, when such men as Pasteur, Charcot, Villemin, Chauveau, Herard, Cornil, Babes, Verneuil, de Saboia, Page, and representative scientists from England, Italy, Spain, the United States, Greece, Hungary, Holland, Belgium, Brazil, etc., sat together under the presidency of

Mr. Chauveau, and took up the general discussion of the momentous question involved in the nature and propagation of tuberculosis and the proper means of opposing its spread.

It was fitting that a French assembly should settle the mooted question of the contagiousness of tuberculosis. True it was first scented by the famous Morgagni, ages ago; and later on Andral and Laennec suspected its infectious nature; but it was not until the bold affirmation of Villemin, supported by numerous and patient inoculations, by Toussaint's experiments, and finally by Koch's discovery of the "bacillus," that the turning-point was reached in the history of tuberculosis.

Since then an immense quantity of corroborative evidence has accumulated, and most striking are the results obtained by the "School of Lyons," proving the identity of human and bovine tuberculosis. Soon afterward this identity was found to hold good with other animal species, and the awful corollary that this plague might be transmissible from one species to another was soon placed beyond cavil.

"What a frightful solidarity between man and beast!" exclaims Mr. Chauveau in his opening address. Frightful, indeed, if we stop to reflect that the air we breathe, the food we eat, the fluids we drink, the clothing we wear, almost every object or living being that we come into contact with, may constitute a source of infection. Hence the fascinating interest that attaches to the proceedings of such a meeting as this, where so many clever heads were put together, and where they earnestly and honestly sought to extract from the scrutiny of the facts before them, from the study of races and animal species, as well as of the means of introduction and propagation of the virus, the general prophylactic laws most likely to lead to its prevention.

It is not my purpose to analyze for the readers of the CLINIQUE all the work of the Congress, for such an enterprise would far exceed the space allotted me in these pages, but I shall endeavor to outline the chief points of interest that are contained therein.

One of the points made is that regarding the danger arising from the use of the flesh and milk of tuberculous animals. I cannot gather from the statistics offered by the veterinarians of the Congress any fixed data as to the percentage of contaminated animals, as 6-1000 seems to be the closest approximation, compared to the healthy.

One thing seems certain, viz.: That too much tolerance is exhibited by the officials in charge of the supervision of meats in Paris and most of the large French towns. In Paris, for

instance, eleven beeves only were seized out of 263,000 turned out for consumption. Now, when we realize how easily the bovine species contracts the disease, and cows especially, we cannot help thinking that the proportion of infected animals must really have been considerably larger.

Assuming that it requires 1,400 people, on an average, to dispose of an ox, it is readily perceived how alarming is the proportion of persons exposed to infection.

That the meat of tuberculous animals contains bacilli is a fact; that these bacilli are not destroyed unless exposed to a temperature of 217° F., a point seldom, if ever, reached, considering how meat is broiled in this country, is another fact; that the bacilli which have found admission into the intestinal tract are not killed either by the saliva or the more potent gastric juice has been recently demonstrated; that they will find their way through the lymphatic system into the blood, and thence into any organ they may select for their abode, has been positively demonstrated. That experimental pathology is trustworthy is shown by the many proofs that are extant, as well as by the very convincing tests which have been made on animals susceptible of tuberculization, such as guinea pigs, rabbits, cats, etc.

In accordance with the above statements, the congress, duly impressed with the importance of their mission, passed a strongly worded resolution to the effect that "*all animals affected in any degree with tuberculosis should be seized and condemned as unfit for food.*" In the light of this resolution, what shall we think of the dangerous practice of sending anæmic and chlorotic patients to the slaughter-houses to drink fresh blood?

The same danger attends the consumption of milk from tuberculous cows, especially when the mammary glands exhibit marked alterations. The opinion of the congress is distinctly that: "*all raw milk ought to be considered as suspicious, and boiled before using.*" We will see, directly, how all-important this precaution is with respect to the feeding of infants. On the other hand, goat's milk may be taken uncooked, as no one ever saw a phthisical goat; and mare's and asses' milk ought to be equally permitted, these animals being somewhat refractory to the inroads of the bacillus.

With reference to the persistence of the tubercle bacilli in river water, it is now proved that in running water at a temperature of about 60° F., the micro-organisms are still active at the end of six weeks. In stagnant water, the virulence may be preserved for seventeen weeks. Moreover, more care and diligence ought to be shown in the utmost disinfection of

tuberculous sputa and dejections, including, of course, the vessels that have been used.

To sum up this chapter of contagion, I will say that the bacillus finds admission into the organism through three main inlets, viz.: the pulmonary, the digestive and the genital tracts. Cornil's graphic and masterly report on the subject conclusively shows that the bacilli can penetrate *the unbroken mucous surfaces*, finding their way through the epithelial layers to the deeper tissues. The cases he cites of localized tuberculous affections in the uterus and cervix are plainly attributable to vaginal infection. Quite analogous are the cases of tuberculous lesions of the lungs, experimentally produced by the inhalation of fluids containing tuberculous matter held in suspension. My friend and townsman, Dr. Thaou, of Nice, fell a noble and untimely victim to such experiments, conducted in Cornil's laboratory.

Another capital point, literally teeming with interest, in these transactions, is the complex question of the various conditions that seem to favor or to restrain the development of tuberculosis. What I am inclined to consider as the most telling and conclusive communication in that line was presented by Dr. Landousy. For years past the Doctor has had charge of the "creche" in Hospital Tenon, and as the direct outcome of his wide and varied experience with the diseases of infancy, he comes forward with a revelation which bids fair to create a revolution. In opposition to the current notion, he affirms that nothing is of so frequent occurrence as tuberculosis in infancy. From a series of fifty post-mortems practiced upon babies, he gathers that one out of three had succumbed to tuberculosis. Drs. Hayem and Damaschino report similar results.

Here is a new field of investigation for the clinician and the hygienist. Many cases of obscure infantile troubles will seem quite clear hereafter. According to Landousy's observations, whereas in childhood proper tuberculosis tends to some localization, it seems in early infancy to assume the character of a general affection. It is apt to manifest itself through purely inflammatory symptoms. Sometimes nothing but a high fever will be present, without any sign of meningeal, digestive, or peritoneal troubles. At other times it may take on the appearance of pulmonary congestion. Here the morbid process seems to stop short of the granular stage, but necropsy would show within a patch of common broncho-pneumonia the characteristic bacilli. This is particularly the case in the broncho-pneumonia that develops so easily in the course of measles. In fact, all of these latter cases Landousy believes to be distinctly tuberculous.

The morbillous virus creates in the infant organism such thermic and dyscratic conditions as render it a medium eminently favorable to the active germination of the bacillus.

With reference to the pathogeny of infantile tuberculosis he is convinced that the greatest danger lies in the use of cow's milk. Let us remember that *puer totus in stomacho*, and that his faculties of intestinal absorption are almost unlimited. The only practical way of avoiding it is to boil the milk. Nothing is easier, and of greater import. It cannot be too strongly urged upon mothers and nurses that *no infant should be fed with unboiled milk*.

Aside from this and other direct sources of infection, Landousy is of opinion that a great many children are born that are not only *bacillisable*, but actually, *bacillised* from the moment of conception. Here the influence of the father, contrary to the common belief, is predominant. Therefore it strikes a reflective mind that in order to effectively restrain the indefinite propagation of the disease, prophylactic measures must be applied to the hereditary factor of the disease, as well as to the contagious influences. This being the case, why should we not try to get the public mind accustomed to the idea that these principles of selection which are such useful guides to the cattle raisers *ought to be applicable to the human race, and should be used accordingly?*

In the worthy attempt to fix at least partially the determinism of the dreaded disease, the congress, let it be said, did some very good work.

Thus, variola was pointed out as constituting a strong predisponent of tuberculosis. Out of 300 subjects who had had variola, whether vaccinated or not, only six were found to be free of tubercle. Equally well supported is the fact that those individuals who present the characters of what may be called the "Venetian type," the type immortalized by Tiziano's brush, skin soft and white, blue eyes, reddish hair, opulent forms, are so many candidates for tuberculosis.

That some kind of antagonism exists between arthritic, cardiopathic, and atheromatous affections and tuberculosis seems to rest upon pretty solid ground. Newly added to the list is paludism, which is claimed by some worthy observers to confer a kind of immunity on its victims. On the other hand, the alleged antagonism which had been attributed to the typhoid virus has been shown to be a decided illusion.

But one result appears to have been attained which lays a vexed question at rest. I refer to the affinity between scrofula and tuberculosis. The understanding is now that the dividing line may be crossed, and that the former is an atten-



ated form of the latter. The predominance of the lymphatic element in the scrofulous subject is in itself the cause of the tardy growth of the bacillus, owing to an antagonism between this micro-organism and the leucocytes. That both diseases are one and the same, however, has been very satisfactorily proved by experiments on the lower animals, on the principle of their unequal receptivity to virulent influences. Guinea-pigs, for instance, are very sensitive to the tuberculous virus. Their lymphatic system absorbs it immediately, and generalization is speedily effected. Such is not the case, however, with rabbits, whose system is much more refractory. Now if both guinea-pigs and rabbits are inoculated with pus from scrofulous adenitis, all the former will manifest signs of tuberculization, while all of the latter will escape infection. But if a new lot of guinea-pigs be inoculated from the first series, and then a third with the second, the virus will be found to have acquired sufficient activity to carry the tuberculous infection over to the rabbits.

Clinically, it is well worth knowing, as Dr. Legroux very ably pointed out, that those small ganglia localized in the necks of children inhabiting large cities, and subjected to evil hygienic conditions, bear the stamp of a latent tuberculous infection. "Micropolyadenopathy" seems rather a long name for a condition which is apt to cut short so many young lives, still, as it expresses one of the primitive manifestations of the disease, we may adopt it. In support of his thesis the author cites this, a very typical case: "Two years ago a big, healthy-looking child, though affected with polyadenopathy, took the prize in a baby-show. A few months later the same child became a victim to tuberculosis."

Another valuable clinical point was made by Dr. Jeannel, of Toulouse. According to him, whenever there exists a *tuberculous fever*, which is characterized by an increased temperature without any local manifestation of heat, it closely resembles typhoid fever, more especially the so-called gastric fever. Necropsy, however, will easily reveal the nature of the affection in the fatal cases. But when in less acute cases the patient gets better, and later on there is seen to develop a tuberculous process, one is apt to diagnose a tuberculosis engrafted upon typhoid fever. This error can be avoided by the consideration of the fever, whose abrupt ascent reaches 103° and 104° F. within the first two days, remains on a plateau for a few days, thence to drop irregularly. At that moment profuse sweating is observed. At no time is the mind obscured. Dr. Legroux states, moreover, that small doses of antipyrine act beautifully on the tuberculous fever,

whereas it seems to have no effect in typhoid fever. Here we have a remarkable accession to the class of continuous fevers.

The study of the climatic conditions of tuberculosis brought out one point, which will be considered as a strong argument in favor of the frequent alimentary origin of the disease. Dr. Robinson, of Constantinople, related the fact that in one of the healthiest spots in the Taurus mountains there lives a nomadic tribe, where phthisis prevails endemically in the proportion of  $\frac{1}{6}$ . In the absence of any other plausible explanation of the fact, and after closer investigation, the Doctor found out that those shepherds were in the habit of selling their best cattle, themselves feeding upon the diseased ones. This brought to my memory similar cases of phthisis which I had occasion to observe during two summer vacations spent in the Alps and the Pyrenees. They had developed in lofty and lovely sites where I would never have suspected the possible intrusion of tubercle. I was considerably puzzled at the time, and my faith in the altitudes suffered a shock from it. Knowing, however, the parsimonious habits of those mountaineers, there is not the slightest doubt in my mind but those cases of phthisis had their origin in diseased animal food.

The question now arises: Do we fare any better here on the prairie? How do we stand in this huge slaughtering and packing center, where thousands of animals are disposed of and scattered all over the world, in regard to the supervision of tuberculous meat? Is there an expert veterinarian at our stock-yards who is able to detect the tuberculous lesions of the animals, and to decide which flesh is innocuous, and which infectious?

Such sanitary measures have already been adopted in most of the large cities of Europe, and it is highly desirable that we should imitate them in this country. It is only through wise, wide-spread and strict prophylactic regulations that we can hope to abate the steady growth of this devouring plague. The simple, statistical fact that the predisposition of our race to tuberculosis, which from one-tenth, as it was at the beginning of the century, has jumped to the proportion of one-fifth, ought to open our eyes and spur our fighting energies, unless we choose to deserve the cool rebuke contained in this line of Milton:

“Thy will chose freely what it  
Now so justly rues.”

• TO BE CONTINUED.

## Hospital Notes.

### THE EYE AND EAR CLINIC.

#### SERVICE OF PROF. WATRY.

##### CHRONIC CATARRHAL INFLAMMATION OF THE MIDDLE EAR.—

*Case.*—May 3. Man seventy-one years old, in a very good physical condition considering his age, began to have noises in his ears fully two years ago. Occasionally the ears felt stopped up. The hearing was not affected until about one year ago, and has been failing gradually ever since. About the same time that the hearing began to fail, the patient began to be troubled with dizziness, and a dull feeling in the head; at first the dizziness was but very slight, but lately the attacks have been more frequent and severe, especially if he exerts himself a great deal. He is very sensitive to cold air, and takes cold very easily.

The drum heads are somewhat thickened and slightly sunken. The tuning-fork is heard the clearest when placed on the mastoid process. He hears the watch at one inch with the right ear, and at two inches with the left.

Too great importance should not be given to the giddiness of which the patient complains, or else we are liable to make a wrong diagnosis. We have learned from clinical observation that giddiness may exist with almost any form of disease of the ear. By a superficial observer these dizzy spells are sometimes looked upon as originating in the labyrinth, and the patient is treated for Ménière's disease, while a more careful examination would show that the symptom originates very frequently, as it does in this case, in the middle ear.

Some time ago your attention was drawn to the fact, that the labyrinthine fluid may be exposed to pressure from the direction of the middle ear through the fenestral openings. All the pathological changes, such as thickened mucous membrane, especially that lining the fenestral structures, accumulation of secretion, polypi and undue pressure inwards of the ossicular chain, may produce sudden or gradual pressure upon the fluid in the labyrinth, calling forth mild or severe attacks of giddiness. This patient has never had a discharge

from his ears, but you have heard him say that he takes cold very easily, and that he has to use his handkerchief very frequently. Such a confession is often enough to convince us that the patient has what may be termed a catarrhal diathesis.

No doubt the catarrhal inflammation affected only the nasal mucous membrane for a long time, but finally it became more diffuse, and it extended along the Eustachian tube into the middle ear. After the inflammation in the ear had existed for some time, a chronic thickening of the mucous membrane took place, which filled up the tympanic cavity, more or less producing impairment of hearing and pressure upon the surrounding parts.

The history of the case is usually sufficient to distinguish between the dizziness caused from the middle and that from the internal ear. When it is caused through changes in the middle ear, the attacks are at first so slight that the patient attaches no meaning to them, and they are usually brought on by exertion, such as stooping or walking very fast. These movements are sufficient to cause a congestion of the middle ear, which, in addition to the already existing changes, is sufficient to make the patient feel dizzy. On the other hand, in dizziness caused by disease of the labyrinth, the attack is very marked, and comes on suddenly, even without any exertion; or, if the attack is but slight at first, it progresses very rapidly.

Now, with the symptoms already enumerated, a predisposition to catarrh, fullness in the ears, impairment of hearing, bone conduction best, we need not hesitate, although the dizziness is a very marked symptom, to diagnose the case as one of chronic catarrhal inflammation of the middle ear, with secondary symptoms of the internal ear.

Since *Bell.* has a very marked tendency to control these congestions, we prescribe the 3d, to be taken three times a day. We also use inflation to establish an equal tension of the drum-head, and to give mobility to the ossicles.

May 8. The patient's head felt somewhat clearer, the dizziness was not so marked. Had a dull, aching pain in the forehead, with an oppressed feeling in the stomach. *Nux vom.* 3.

May 15. The dizziness is about the same; no headache. *Bell.* 3.

May 29. The patient had taken a fresh cold, and was not feeling so well. Same remedy.

June 5. Had no dizzy spell all the week; the hearing has improved, so that he can hear the watch with the right ear at six inches, and with the left one at ten inches. The same treatment.

July 31. The hearing has been improving slightly; no dizziness. Had an attack of indigestion, for which *Lycop.* 6 was prescribed.

August 9. Felt very much better; continued the same treatment.

ACUTE MUCO-PURULENT OTITIS.—*Case.*—Young man aged eighteen years. When four years old he had scarlet fever, which left his ears in a very bad condition. The right ear discharged for over nine years, then it gradually ceased, and he has had no discharge now for over three years. The left ear never discharged, but whenever he takes a slight cold it pains him, and the hearing becomes affected. Over a week ago, after having been exposed to the cold air, this left ear became very painful, and different remedies have been tried, but without result. There is a constant aching, which is accompanied with a shooting pain from time to time. The drum-head presents a bulging appearance at the lower anterior portion. The color, instead of being of a neutral-gray, is rather yellowish. He hears the watch only when it is placed in contact with the auricle. The drum-head of the right ear is totally destroyed. There is no sign of any discharge, and the mucous membrane in the tympanic cavity looks rather pale and atrophied. He hears the watch with this ear at five inches.

This young man has been troubled for almost fourteen years with an inflammation in both ears. The inflammation in the one ear was for a very long time of a suppurative nature, while that of the other ear developed into the chronic non-suppurative form. We are all aware of the danger that threatens such an ear when an acute exacerbation takes place. The patient, whenever exposed to a change of the atmosphere, is liable to have an acute attack of a muco-purulent nature, with the most serious results. Here we have a typical case of such a complication. The bulging of the membrano tympani is caused by the muco-purulent inflammation, the secretion be-

ing pent up in the tympanic cavity, pressing upon the drum-head and the surrounding parts, causing great pain.

After suffering for some time with severe pain, the patient usually gets relief by a spontaneous perforation of the drum-head; or the swelling of the Eustachian tube may go down and give exit to the secretion. The pain in such cases is usually relieved by the hot douche; but this procedure is somewhat dangerous, as we are liable to cause maceration of the drum-head, and when perforation occurs the pus carries off the whole membrane.

The safest way to proceed with such a case is to perform paracentesis. A narrow-bladed cataract knife, such as I hold in my hand, answers the purpose very well. The drum-head is incised at that portion where it bulges the most. Looking into the ear again we see quite a different condition. The bulging portion has collapsed and the incision is filled with a yellowish secretion mixed with a little blood. We now proceed to free the cavity by inflation, gently syringing and drying the parts with the probe and cotton.

To the patient's surprise there is no more pain, and he can now hear the watch at six inches. We will have him wear cotton in his ear and give him *Hepar sulph.* 3.

Two days later the patient reported, that there has been no discharge, and but very slight pain. Inflated the ears and changed the remedy to *Calc. carb.*

This patient kept on improving, and when seen last, he could hear the watch at twenty inches with the right ear and at twenty-four with the left one.

CHRONIC CATARRHAL INFLAMMATION OF THE MIDDLE EAR WITH TINNITUS AURIUM—*Case.*—February 14. A woman twenty-eight years old, has been troubled with noises in her ears from the time she was eight years old. As a rule they are of a buzzing character, and are much louder in the right ear. About three years ago she had pain in her right ear for several weeks, which was finally relieved by a profuse discharge from the ear, and which also lasted for several weeks. She has had no discharge since that time. The drum-heads are very much sunken, and present a rather milky appearance. There is considerable mo-

bility to that of the left ear, but the mobility of the right drum-head is very much impaired. She can hear the watch at ten inches with the right ear and at five inches with the left one.

Noises in the ear is a common symptom in all forms of ear diseases, and it is often more annoying to the patient than the defective hearing with which it is most always associated.

When the patients are asked to describe the noise in the ear they often have a difficulty in comparing them. These sounds are often compared to the buzzing of bees, the humming of a shell, the singing of a kettle and the blowing of a pipe; some are said to be like the bursting of bubbles and the splashing of water. These noises may be caused through three different mediæ: (1) by morbid products near, or at the roots or trunk of the nerve; (2) by abnormal pressure or tension of the labyrinthine fluid; and (3) by reflex irritation. In this case the tinnitus is no doubt explained through the second media.

We have observed that the drum-head in each ear is very much sunken, and that its mobility is greatly impaired. A similar condition points to the fact that the middle ear has either been in an abnormal state for a very long time, or that serious changes must have been going on which caused adhesions of the drum-head.

There is one point in this case which might seem rather puzzling to some of you, which is that, although the noises are very much louder in the right ear, yet the hearing is decidedly better on this same side. The reason for this undoubtedly is that, although a great deal of exudation has been thrown into the right tympanic cavity, the ossicles themselves are not as much implicated as those on the opposite side, and it is most probable that there is a partial ankylosis of the ossicles in the left ear.

The prognosis in a chronic case like this is unfavorable, yet we should not feel discouraged, for similar cases are bound to grow gradually worse until they are totally deaf, or until the noises become so severe as to drive them almost to suicide.

By treating the ears twice a week with inflation, and giving the patient constitutional treatment, I think we can check the neural trouble, and may do the patient some good. She complains of a dull aching headache, with fullness in the stomach, and is quite constipated. Gave her *Nux vom.* 3 three times a day.

March 6.—The noises and the hearing were about the same. The full feeling in the stomach was relieved, and she was less costive. She has had severe headaches, beginning at the nape of the neck and passing over the occiput, and she feels sensitive to the cold air. *Calc. carb.* 3.

March 20.—The noises were somewhat less in the left, but no change was noticed in the right ear.

April 17.—The patient was still improving.

August 28.—There was no noise in the left ear, and the right one had perceptibly improved.

ULCERATIVE KERATITIS.—*Case.*—July 31.—A tall, slender and sallow complected woman, twenty-nine years old, came to the clinic with a diseased eye. It was nearly two weeks since that the right eye began to be very painful and sensitive to the light. The cornea presented a large infiltration, which extended from the nasal side almost over the whole pupil. The infiltration had a lardaceous appearance, and was somewhat raised above the healthy corneal tissue. There was a marked zone of conjunctival and sub-conjunctival congestion, but no superficial vessels were seen running toward the infiltrated surface, as is usually the case in ulcers of the cornea. As the ulcer appeared to run into a chronic indolent form, it was judged best to scrape its surface very gently, and, in order to produce more stimulation, hot fomentations were ordered to be applied four times a day, about half an hour each time. A four grain solution of atropine was dropped in after each hot application, and the eye protected by a bandage.

The patient's health was quite poor, and she complained of a number of symptoms which indicated *Calc. carb.* This was given three times a day.



August 7.—Quite an improvement was noticed. New granulations had been thrown out, the infiltration looked less opaque and had changed to a healthier appearance. The appetite had improved, and the patient expressed herself as feeling better. The pain was, however, quite severe at times, especially during the night. The same treatment was advised, excepting that the hot applications were to be used only twice a day.

August 16.—The eye looked very much better. The cornea was clearing up, and she had had no pain for several days. Although the general health was improving, the patient was anxious to go in the country for a short time, and has not been seen since.

CHRONIC CATARRHAL CONJUNCTIVITIS WITH OBSTRUCTION OF THE TEAR-DUCTS.—*Case.*—May 22. A woman fifty-seven years of age complains that her eyes have been weak for over twenty years. As near as she can remember, when they first became weak, the lids used to be slightly glued together in the morning, and she had a feeling as of sand in the eyes. Of late years the lids have not been glued together, but they feel heavy and stiff. The eyes began to overflow about eighteen years ago, when exposed to the cool air, but for the last fifteen years they also weep more or less in the house. They look watery, and occasionally a tear trickles down over the cheeks. The everted lids show the conjunctivæ to be somewhat thickened and slightly inflamed.

The usual operation for opening the tear-duct was advised, but the patient dreaded the knife and would not submit to the operation. A two-grain solution of the sulphate of zinc was then advised to be applied to the eyes twice a day, and no internal medicine was given. The patient reported every three weeks and felt more encouraged each time. When last seen, only about three weeks ago, one of her eyes had ceased to weep, while the other overflowed only slightly when she was out of doors.

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ABSENCE OF THE ROUND LIGAMENTS.—Dr. H. I. Ostrom, of New York, sends notes of the following very interesting case: "The case was one of long lasting complete prolapsus of the uterus, with bilateræ laceration of the cervix. I first did trachelonhaphy, using for the purpose juniper cat-gut. The dislocation of the uterus made the use of a speculum unnecessary, the entire cervix being outside of the vulva. In making Alexander's operation the inguinal rings were reached without difficulty, but the most careful search, carried almost to a dissection, failed to find the slightest trace of the round ligaments. These structures had either become atrophied from prolonged stretching, or were possibly congenitally absent. On the left side the abdominal opening was so large that a considerable piece of omentum protruded before I had finished my search for the round ligament. I feared hernia, and therefore secured the opening with the valve hernia stitch of MacEwen, using the same three weeks cat-gut that was used upon the cervix. Both the abdominal wounds healed with only slight suppuration. Of course the position of the uterus was not altered by the operation."

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## Miscellaneous Items.

The meetings of the Clinical Society will hereafter occur on the last instead of the first Saturday evening of each month, beginning with a report from the bureau of Surgery, September 29. — Dr. C. M. Dinsmoor, of Omaha, has taken Dr. William A. Humphrey into partnership. — The new and grand Homœopathic hospital of Detroit will very soon be ready for occupancy. — W. S. is informed that we have no space for articles and cases that are also sent to other journals. — The doctors who “practice among the better classes” are returning from their summer vacation. — The students are swarming to the old Hahnemann, which will open on the 18th with a full house. — Dr. E. K. Thompson has taken the practice of Dr. A. P. Evans, at McPherson, Kas. — The Southern Homœopathic Medical Association will meet at Louisville, Ky., October 10–12. — Dr. W. R. Stephens, class '87, and Miss L. O'Rourke were recently married at Alleghany City, Pa. — Dr. Alfred W. Hoyt, of this city, will give a course on “Dental Medicine” to the students of the old Hahnemann this winter. — Mr. Percy Bollen has gone home to South Australia for a year's vacation. — Mrs. Dr. Bowerman has contributed a “History of the Woman's Homœopathic Medical Society of Chicago,” which is now in its tenth year, to the *Medical Visitor* for August. — Prof. Crawford's papers, the third of which is published in this issue, are attracting a great deal of attention. — Dr. W. A. Dunn, professor of Laryngology and Rhinology, has returned from the Vienna clinics, and will be ready for the opening of his own clinic in the Old Hahnemann September 18. — Dr. A. S. Eshbaugh, '86, was married to Miss R. M. Tisdale, at Lexington, Ill., August 30, and Dr. G. B. Bushee, '87, to Miss Ada L. Hatcher, September 11.

# THE CLINIQUE.

[Vol. IX.]

CHICAGO, OCTOBER 15, 1888.

[No. 10.]

## Original Lectures.

### THE OPENING OF THE TWENTY-NINTH ANNUAL WINTER SESSION OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

The annual reopening of this flourishing school of instruction took place, according to public announcement, on Tuesday evening, September 18, 1888, in the hospital amphitheatre. Besides the Board of Trustees and the Faculty, a large number of physicians, alumnæ and students were present. The exercises were opened with prayer by the Rev. Dr. Bland, of the Methodist Episcopal Church, and the music was furnished by the Imperial Quartette. The chief attraction of the evening, however, was

THE ADDRESS BY THE PRESIDENT OF THE COLLEGE, DAVID S. SMITH, M. D.—Being delivered *extempore* and bristling with good points, it is quite impossible to present a correct and complete report of Dr. Smith's speech. The old students of the College, and those who have heard him on former occasions, will appreciate its tone and spirit, and the rousing enthusiasm with which it was delivered. Its forcible delineation of the early days of Homœopathy in the great Northwest, and the contrast between the popularity of the system when there were no colleges, nor journals, nor students in all this extended country, and the present, with its extensive patronage and popularity, when hundreds of pupils are

swarming to our schools of instruction, was drawn in glowing colors.

Coupled with this was the earnest counsel to the class to make the best of their opportunities in an institution which had had and still has such illustrious teachers, and which already has such a glorious band of alumni scattered up and down the earth. A touching tribute was paid to the memory of those members of the Faculty who had passed the dark river to their final reward—BEEBE, the famous and intrepid surgeon; COOKE, the versatile physician and the distinguished diagnostician; and SMALL, the grand old man, whom everybody loved, and who had labored in season and out of season for the best interests of this school and of the profession at large.

The most pleasant reference was also made to the services which had been rendered to the institution since its reorganization by Prof. G. A. Hall, who was present to participate as of old in the festivities of the occasion, and who had deemed it best that he should withdraw from its teaching corps. This change in the Faculty was not the result of any unkind feeling, or of a loss of interest in the prosperity of the college, or in the welfare of the class. It arose from the determination of Prof. Hall to unload his excess of cares and to devote himself to other professional matters in which he thought he could better subserve the ultimate interests of the school. His place would be filled, so far as it could be filled by any one, by Prof. Shears, who for seven years past has done most faithful and acceptable service in the surgical department of the college and hospital. The new lectureships and clinics would doubtless prove a useful and welcome addition to the curriculum.

After a choice selection by the quartette and an *encore* came the following Introductory Lecture by Prof. Ludlam:

*Ladies and Gentlemen:* I never attempt an address on an occasion which is so interesting and so important as this without recalling the *dictum* of Pythagoras: "Hold your tongue, or say something better than silence."

And what can I say that is better than silence? My con-

gratulations to all who are concerned in the reopening of this School will surely be in order as they are in earnest. You have come hither to cement old ties and to form new ones; to engage in an arduous pursuit with a lofty purpose; and I can only emphasize the welcome to which our worthy President has given so happy and so hearty an expression.

An eminent American author has said: "There are three wants that can never be satisfied: that of the rich, who want something more; that of the sick, who want something different; and that of the traveller, who says anywhere but here." If to these he had added a fourth for the typical medical student whose thirst for knowledge is insatiable, he would have included those who, like yourselves, will never be fully and completely satisfied with their present attainments.

But, although it may be fitful and intermittent, coming with increased severity during the months of September and October, and declining in the early spring, this last symptom is not necessarily morbid. If the proper fountain can be reached, and its waters are taken as they should be, it may become a sign and a source of healthy, intellectual expansion and development.

The oculist will sometimes say of an old person that "his power of accommodation is lost." In a kindred sense the power of accommodation is what makes the difference between the men and women, the students and physicians who succeed in life and those who do not. You will be lost in this school and hospital if you fail to accommodate yourselves to your privileges.

All genuine progress is the fruit of observation and experience; but we can not observe correctly if our mental vision is impaired and imperfect. Those who are totally blind are exempt from visual illusions; but the student who has a mental squint will fill his head, if he fills it with anything, with wrong impressions, distorted facts, half truths, and rubbish.

In these days of expanding intelligence one needs to keep his eyes open, and to be on the alert that nothing which concerns his training for the exigencies of practical life shall escape his observation. Merely to listen to the lectures, or

to survive the clinical course, is not all that will be required of you, for what you hear and see and read must be recorded and digested. A worthless experience will surely spring from faulty observation, just as slovenly writing is the outcome of careless thinking.

It is quite a common thing for those of us who have reached the period of life which Lord Beaconsfield called "anecdotalage" to compare the present with the past, and to deplore the degeneracy of modern times and of the standard of modern attainment. Among these old Fellows there is a deal of ridiculous whining about the relative unfitness of the men and women who are now living, the doctors of the present generation, for the duties that lie in their way. But the simple truth is that, if they are not very much better qualified than their predecessors were, it is their own fault.

Look for a moment at a few of the changes and improvements that have taken place since I enlisted as a medical student. It was my privilege to matriculate in one of the oldest, and at that time the best old school medical college in America, from which I graduated after three *full*, not fractional or piecemeal courses. I saw a great deal of practical surgery in the college and the hospital clinics, but in the whole three years I never witnessed an operation under anaesthesia. In every case the patient was held upon the table by main force, usually by three or four strong students, and the operation was performed amid cries and groans and signs of suffering that would have touched the heart of a tax-gatherer. It goes without saying that, although my teachers in this department were renowned for their skill and experience, much of their surgery was what would be called rough and coarse at the present day.

It has been said that "the true inquisitor is a creature of policy, and not a man of blood by taste." In those days the majority of the students set out with the idea of becoming surgeons, just as they do now, but the scenes of the operating room soon scared the most of them out of that notion. For they found that something of the bull-dog tenacity, and something of the taste for blood must be coupled with the

surgical instinct if they were to succeed under such trying circumstances. Indeed, those very exhibitions had a natural tendency to blunt the finer feelings and to develop the coarser qualities of the mind and the heart.

The teachers and pupils of that period knew as little of the delicate possibilities of our modern surgery as Hippocrates, with all his learning, knew of the Latin language, or as Hahnemann, with all of his scientific attainments, knew of the clinical thermometer. And for the simple reason that the operations, which we are now making so skillfully and so successfully, were not practiced, and were not possible until the patient could be put into a deep sleep, like Adam when he was made ready for that primary operation in the Garden of Eden!

Moreover, from the date of the first introductory lecture—and they consumed about a week at the beginning of each session—to the day upon which we took our final departure, clothed in sheep-skins, no member of the class ever heard a word concerning antiseptic medicine, surgery, or midwifery. The microbes had full sway, and sanitary science, excepting in the matter of vaccination, was in a very rudimentary state.

Only a few years before physical diagnosis by mediate auscultation, that wonderfu' discovery of Laennec had been introduced into this country. It was subjected to derision, and there was a current story that in describing such an examination, one of our professors had paraphrased old Dr. Sam. Johnson's definition of the angler so as to read: "A patient at one end of a wooden tube and a fool at the other."

In other fields our advantages were far behind those which you will enjoy in this institution. In the matter of uterine diagnosis and pathology, each term afforded us a few lectures upon the "irritable uterus," and displacements, but none of us ever saw the sound or the speculum. The clinical history of pelvic peritonitis, and of kindred affections that are now as familiar as pleurisy or pneumonia, was unwritten and unknown.



Sims was then a country doctor and did not begin the publication of his discoveries, which afterward became the corner stone of American gynecology, until 1852. It was not until 1853 that Dr. Walter Burnham, of Lowell, Mass., first removed the uterus and its appendages for fibroids; and as late as the year 1855, a leading surgeon of New York (not Dr. Helmuth) taught his classes that "not more than 1 per cent of the cases of ovariectomy could possibly prove successful." The most reliable records show that down to 1850, when I was on my seat in the lecture-room, only 174 ovariectomies had been performed in the whole civilized world, and that of these ninety-four cases had recovered and eighty had died!

At that time there were no antiseptic sutures or dressings; only two surgeons (Mettauer, of Virginia, and Sims, of Alabama) had employed the silver-wire suture; the catgut sutures, which had never yet been carbolized, were doing service on all the old fiddles in the country, and the silk-worm gut had not been stolen from the fishermen. Laparotomy, abdominal drainage, aspiration, enucleation, trachelorrhaphy and other gynecological operations with which it will be my privilege to make you practically familiar, were as unknown to the profession as the telephone, the electric light and the cable cars were to the people. There was not a Woman's Hospital under the sun, and there were a thousand gynephobists (or those who were afraid of the women) to one gynecologist, with the very natural result that if she could possibly avoid it, no woman would come within a mile of a medical school, either as patient or pupil.

The domain of nervous diseases was almost wholly undeveloped. Cerebral anatomy was carefully taught, and there was always enough of it to satisfy the student, but the physiology and the pathology of the brain were very imperfectly understood.

Cerebral localization had not been naturalized. In one sense the whole subject was at the finger-ends of the long-haired men and the short-haired women who had an unbounded faith in phrenology; but, in case they were upset by

disease or accident, nobody else could locate our mental faculties. The cerebral surgery of the time was limited to lifting the depressed bone in case of fracture of the cranial vault; and for the lack of ability to identify the site of the lesion, as well as because there were no anæsthetics or antiseptics in use, the removal of brain and spinal tumors, the opening and drainage of pus cavities and of serous accumulations had not been practiced. In those days nobody had ever heard of such splendid achievements in brain surgery as some of you have already witnessed in this very amphitheatre.

The patellar, the aural, the organic, and other reflexes were unknown. We never dropped the word "aphasia," because the convolution of Broca had not yet picked it up; and, for that matter, Broca had not found his own convolution! My colleague, Prof. Arnulphy, who was his pupil, can tell you how Broca worked with the dead as well as with the living to locate the organ of language, and Prof. Fellows will teach you the clinical significance of his discovery.

So, my friends, without going further into this subject, or taking up your time with recounting other relative disadvantages of my own student-life, it is obvious that the circumstances which surround you are peculiarly auspicious. Your starting point is a long way in advance of ours. You step at once into the clearing and freshening atmosphere of medical science. The inclination and aptitude of the professional and the public mind are greedy for the best views in every branch of knowledge. To be surrounded by such conditions, and to be certain of an appreciative clientele, when you have taken the honors of this school, are powerful incentives to diligence and fidelity on your part. I know that your opportunities are of the very best, and I believe that you will appreciate and improve them.

I revered my teachers and their attainments. They have all passed to the reward of good and faithful servants. If their voices had been hushed for an hundred instead of almost forty years, I would not breathe a word of disrespect. For nothing is so mean, and no spirit is so contemptible as that which abuses the institutions from which we have sprung,

and the instructors who taught us the elements and the essentials of whatever we know.

It sometimes happens that men who are distinguished lose a great deal in our estimation when we view them closely. But it was not so with my teachers, and I earnestly hope that it will not be so with yours. Their scientific stature was something to be admired and coveted, and something to be remembered with pleasure as the years roll on. If any of their pupils have surpassed them in their ability to unravel the tangled skeins of disease, to save suffering and to prolong life, the fact must be charged to the extraordinary evolution of the medical sciences that has taken place since their day.

You will not fully realize the post-graduate work that some of us have done, in order to keep step with the procession, until you also can review your course in the light of improvements of which at present we know but little or nothing. If you take the same pleasure that we have taken in the long and arduous pursuit, and shall turn to this hour with feelings of gratitude for the sympathy and encouragement that we have given you, the retrospect will not be painful, and we shall all be remembered by what we have done.

“Needs there the praise of the love-written record,  
The name and the epitaph graved on the stone?  
The things we have lived for, let them be our story,  
We ourselves but remembered by what we have done.”

“I need not be missed, if my life has been bearing  
(As its summer and autumn moved silently on)  
The bloom, and the fruit, and the seed of its season;  
I shall still be remembered by what I have done.”

“I need not be missed, if another succeed me,  
To reap down those fields which in spring I have sown;  
He who ploughed and who sowed is not missed by the reaper,  
He is only remembered by what he has done.”

“Not myself, but the truth that in life I have spoken,  
Not myself, but the seed that in life I have sown,  
Shall pass on to ages—all about me forgotten,  
Save the truth I have spoken, the things I have done.”

“So let my living be, so be my dying;”  
So let my name lie, unblazoned, unknown;  
Unpraised and unmissed, I shall still be remembered;  
Yes, but remembered by what I have done.”

Following this came another song, and still another, which were most warmly received, and then a brief lecture .

ON MODERN SCIENTIFIC MEDICINE, AN INTRODUCTORY ADDRESS.—  
BY PROF. C. E. LANING.—I have been highly interested in listening to my colleagues who have just preceded me, and not only on account of what they have said, and what they have taught us, but also for the reason that they have opened to our view the magnificent possibilities of *modern scientific medicine*. When we note the wonderful strides which have been made in this direction during the life-time—the medical life-time, we may say—of these men, does it seem unreasonable or fanciful to predict yet greater discoveries, and a still nearer approach to the day when Medicine shall justly claim of all men the right to be considered one of the exact sciences?

Not only have these thoughts been suggested by the eloquent words of my colleagues, but it also comes to me with striking force, that you, some of whom are sitting for the first time in a medical college, are the ones to look to for great endeavors in this line. Why should not some of you be to medicine what a host of other patient, persistent, self-sacrificing men have been? Those men have materially helped in bringing medicine from the chaotic condition in which it was a few centuries ago, up to the splendid position it now holds. And yet Hahnemann and others of our own school, together with those of all other schools and systems, have not discovered all there is in Medicine. Indeed, all the men of all ages who have preceded us have only been engaged in laying the foundation upon which you and I should strive to place at least one stone each of the great superstructure which is to represent modern scientific medicine. There is no room for drones in our profession, and each and every one of you should enter upon your studies with the determination of being *workers*.

How delighted would such men as Hahnemann, Majendie and John Hunter, and many other active workers of a few decades ago, have been to have had the mass of scientific

medical information that we possess to begin their studies with, and to have had the means for investigation which we have to-day.

You do not, you cannot, realize the great advantages which you, as medical students of the present time, have as compared with those enjoyed by students and physicians a few centuries ago. Imagine, if you can, what it was to be groping around for medical light, for medical truths, without knowing that the blood circulated, and still believing that the arteries contained air during life. How successful do you suppose you would be in the treatment of catarrh if you still thought that the little appendage of the brain—the pituitary body—consisted of mucus, as did the physicians and anatomists of the time referred to, when they gave it the name which it holds to this day, and which literally means a body of mucus. They thought that the secretions falling from the posterior nares into the pharynx in catarrhal affections dropped from the pituitary body, and hence called the disease “catarrh,” which means “to drop.”

And even Michael Servetus, who was one of the learned men of his day, and who practically knew, or theoretically inferred, that the blood circulated long before Harvey dreamed of it, maintained that this same pituitary body was the seat of the soul. He described how the devil, passing up through the cribriform plate of the ethmoid bone, seized the little body containing the soul, and made off with it. It must have been hard lines for the old fellows of those days to think that their souls were so accessible to the arch-fiend; and the only consolation they could have had must have been in knowing that if they lost their souls the pituitary body went with them, and hence they would be forever relieved of their catarrh!

In entering upon this field, if you do not possess an inquiring mind, try to cultivate one. Do not allow yourselves to become animated sponges, simply to absorb, or parrots to repeat what may be presented to you during the term of lectures upon which we are now entering. Do not be like a student whom I once knew, who was a great, fat, lazy, good-natured fellow, who always took things so easy that his

ellow students wondered how he ever expected to get through, and so asked him one day. "Oh," he replied, "if you only stay here long enough they'll pump it all into you."

Now, I am certain that I can speak for the Faculty when I assure you that they do not desire to be obliged to convert themselves into a set of mental force-pumps; they expect to work hard, and expect you to work harder. Learn to think, to reflect, and to take up the thread of discovery where it drops from the nerveless hands of your older colleagues, and to push on toward truth and scientific medicine. We have just reason to believe that in the years to come great advances will be made in our profession. How pregnant these years may be with scientific medical truths depends largely upon you.

Do not feel that a certain elect few are always to be the leaders, and that all you have to do is to follow them. When you shall have entered upon the practice of medicine you will owe as much to your profession, to your *clientele*, as does the member of any other profession. Above all do not join that class of men who are a bar to progress in all directions, those who think that more knowledge is unnecessary, and who, like the Chinese, continue to plow with pointed sticks because their fathers and grandfathers did so before them; men who think that because a mere superficial knowledge of the laws of nature has been attained, and because the general outlines of some of the arts and sciences have been mapped out, there is nothing left for them to do.

The science of medical electricity is yet in its infancy, and promises as it develops great assistance to the physician. Already more or less practical results have been obtained in the way of illuminating the various cavities of the body; and the ability to register with great accuracy and delicacy the temperature of the different portions of the body by the aid of electricity, warrants us in believing that it may help us materially in arriving at the nature and location of the morbid changes occurring within the cranium. By its aid, together with appropriate instruments, it is not at all improbable that in the very near future we shall be enabled to detect

sounds which to us are now as a whisper to the ear of a deaf man; sounds by the proper interpretation of which we may recognize pulmonary or cardiac lesions, those of the gastrointestinal tract, or possibly those of other organs at such an early stage in their development as is now absolutely impossible to the most skillful practitioner. I believe that by the aid of electricity, together with various delicate instruments which will yet be devised, we will yet be able to detect the slightest changes in the organism that are abnormal in character. In this way we may hope to gain much knowledge of a positive kind regarding the tissues acted upon by our remedies, and, as a result, arrive at an accuracy in prescribing which is greater than has been possible since the foundation of the world.

When this degree of knowledge shall have been attained, as I believe it will be, death, or lingering suffering as a result of disease, must largely disappear, for all diseases will be recognized in such an early stage that the physician may in almost all cases successfully combat them.

As a further illustration of the advance which medicine has made during the past few years, I will quote from memory an extract from an introduction to the chapter on the diseases of the brain in what was at that time a standard text-book. As near as I can recall them they ran thus: "The brain is an organ locked up in a bony box; we can neither auscultate nor percuss it, nor see it, hence it is impossible to know anything positive regarding the diseases which affect it."

And while this was almost literally true when that work was published, to-day, in spite of the "bony box" which encloses the brain, or the bony canal which protects the spinal cord, there is perhaps no portion of the body in which the site of a lesion can be so accurately, definitely located as in the brain and the cord. The first operation for the relief of an abscess of the brain, made under Charcot's direction, has always challenged my admiration. The surgeon removed a piece of the calvarium by trephining at the point indicated by Charcot, when the latter, having localized the lesion beforehand, took the trocar and plunged it downward into the brain.

the pus welled up and overflowed the wound, and this marked a new epoch in medicine. It confirmed and established the clinical value of cerebral localization, to which my colleague is just now referred.

With such a knowledge of the nervous system I do not believe the time need extend beyond that of the natural life of many of you present to-night, when the words of one of our masters in medicine will be proven a mistake. He said that while the veriest tyro might talk of the action of drugs upon the nerve centres, no one would ever know upon what centres they do act." The many careful and positively faultless experiments which have been made regarding the action of drugs, has demonstrated, conclusively, the centres upon which certain drugs act. Variations of blood-pressure, local and general, modified nerve-power, increased or diminished activity of the various tissues of the body, have been carefully studied while the individual has been under the action of a certain drug of a certain strength and quantity.

But while you are endeavoring to keep pace with the progress of therapeutics you should not forget the other branches of medicine. You should be thoroughly acquainted with the *clinical history* of disease, in order that you may have a definite knowledge of the effects which your remedies have produced in a given case. Too often the practitioner, from not being familiar with the normal variations, exacerbations and ameliorations which occur in disease, ascribes them entirely to the action of his remedies.

What should you think of a physician who gravely reported a case of typhoid fever in which he should claim that his remedies produced an alternate rise and fall of the patient's temperature morning and evening; or a case of fever in which the remedies caused a decided aggravation one day to be followed the next by an almost complete abeyance of all the symptoms? Of course in typhoid or remittent fever the clinical history is so well known, so decidedly marked, that no one at this day would make such a mistake.

Still there are other diseases in which the periods of aggravation and amelioration are less pronounced and not so regularly periodical, yet in which these changes are nevertheless as much a part of their clinical history as the variations of temperature are of typhoid fever. But, for the reason that they are more subtle and less regular in their appearance and disappearance, they are overlooked by the practitioner, or what is even more harmful, are ascribed to the action of remedies.



Some physicians are so prone to this sort of blundering that they remind me of an incident which a gentleman told me of the other day. A number of years ago my informant was traveling on a small vessel on the lake when a man, who had evidently not been bred upon the waters, desiring to dip up a little water, leaned out over the stern of the boat, and just then, as a result of the action of the wind and waves, the vessel's bow lifted and her stern was correspondingly depressed. Springing back upon the deck with every appearance of dismay, he involuntarily ejaculated, "Gosh, did I do that?"

So it is with many physicians who are either alarmed or elated at the effects produced by their remedies, whereas in truth they have had nothing more to do with the changes observed than that man had with the lifting of the bow of the boat.

I have not touched upon the importance of chemistry nor of the microscope in medicine, nor shall I at this time, as the theme is too great, but must leave you to commence on the morrow, under the tuition of the Faculty, the study of *Modern Scientific Medicine*.

#### THE ANNUAL REUNION AND BANQUET.

Every friend of the college knows that it is an established custom to open its Winter Session with a social reunion, which is held in the Hospital, and which occurs at the close of the Introductory exercises. This year's Reception came, therefore, as a natural consequence. Under the excellent management of Dr. Shears, Superintendent of the Hospital, with the assistance of the House Physicians, the matron and the nurses, it was a pronounced success. More than ever, if possible, it seemed to fuse and cement the common interest of teacher and pupil, and to place the new and old comers, the alumni and supporters of the institution and all concerned on a freindly level of sympathy and companionship.

After a formal introduction, the name and State from which each student had hailed being announced, the large party spent an hour over the refreshments, in the most enjoyable manner. The music, the fruit and the flowers, the presence of the ladies and the good feeling all around and everywhere, made the occasion most enjoyable. Brief after dinner speeches were made by several by members of the Faculty, and Prof. Hall explained his resignation from the Faculty and his continued and abiding interest in the institution.

## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

The regular monthly session of the Clinical Society was held in parlor 44, of the Grand Pacific Hotel, at 8:30 P. M., Saturday, September 29, 1888. There were present seventy-five members and visitors. Dr. W. S. Gee, first vice-president, presided. Dr. E. J. Leonard, 597 W. Twelfth Street, was proposed for membership by Dr. R. Ludlam, Jr.

The report of the evening was made by the Bureau of Surgery, Dr. George F. Shears, chairman.

CASES SIMULATING INGUINAL HERNIA.—BY DR. G. F. SHEARS.

—It is my purpose this evening to present to you the records of several cases that have come under my observation in which diagnosis of hernia had been improperly made, with a few remarks as to the signs of hernia.

*Case 1.*—William B., æt. thirty-four, Elgin, Ill., has a pronounced enlargement in the upper portion of the left scrotum. First noticed the trouble three years ago after a hard day's labor. The enlargement was then slight, but has gradually increased in size. On lying down the tumor disappears, but returns on assuming the erect posture. There is no severe pain, but a constant sensation of weight. After severe work, or after an attack of constipation the tumor becomes much enlarged, and quite painful. At such times the swelling does not disappear entirely upon assuming the recumbent posture. By the use of hot poultices, and by remaining in bed for a few days, the swelling is relieved, and he is able to continue work. He has been advised to have the tumor resected or to wear a truss.

Upon examination the doughy bunched-worm feel of the hydrocele is recognized. No hernial protrusion is present. There is no impulse on coughing, the inguinal ring is not enlarged. Upon closing the external ring and allowing the patient to take the erect posture the swelling returns. The testicle is thickened, as is also the epididymis.

This is a pronounced case of varicocele. The occasional pain and swelling, that does not disappear on lying down, is probably due to epididymitis or orchitis of a sub-acute character. A supporter was advised, and Hamamelis given internally. Much relief followed.

*Case 2.*—Mary D., æt. eight years. Sent me by Dr. E. B. Thomas. For some time the child has been less active than usual, but has complained of no pain. While bathing, the mother noticed a swelling in the right inguinal region. The tumor seems to make its exit at the external abdominal ring. It is prominent when the child stands; is compressible and reducible. Upon coughing the tumor becomes larger and tenser, a distinct cough impulse being felt. The tumor is not sufficiently prominent to obtain a view by transmitted light. On slight percussion the sound appears to be dull.

The abdomen is very prominent, and the child walks with the shoulders well thrown back. Upon removing the clothing and examining the spine a slight prominence is discovered at about the eighth dorsal vertebra. Pressure produces no pain, and flexion of the trunk is made without difficulty.

A diagnosis of psoas abscess from Potts' disease of the spine was made, and the opening of the abscess recommended. The parents were loath to have it opened, as it had been pronounced a hernia, and the operation was deferred. Three weeks later the child again presented, with a somewhat similar swelling in the lumbar region. Believing the two enlargements to be due to the same cause, the lumbar swelling was aspirated and pus obtained. The parents were still unwilling to have the inguinal tumor interfered with, but consented to the opening of the lumbar one. Nearly eighteen ounces of pus were obtained, and upon its evacuation the tumor in the groin disappeared and the abdomen was much decreased in size. As the case progressed deformity became more and more apparent.

*Case 3.*—Was requested by Dr. E. M. P. Ludlam to see a little child six months of age, who was suffering, his parents had been told, from irreducible hernia. The history was as follows: Some days previous the child had become very

nervous and irritable, and had been taken to a regular physician. He examined the child and found a swelling in the scrotum which he pronounced a hernia, and declared was the cause of the child's pain and distress. He attempted to reduce the swelling, but did not succeed. Another physician was called in, chloroform given, the hernia said to be reduced, a truss applied, and the patient sent home. As the child did not improve, and as the swelling had made its appearance below the truss, Dr. Ludlam was called. He administered some remedies that gave relief, and with him I saw the case. The symptoms then present were: A tense, circumscribed tumor reaching from the external ring to the testis. Upon pressure the tumor could be pressed up so that it was apparently reduced, but more careful examination showed it to be pressed up into the abdominal subintegumental tissue, and that it instantly returned irrespective of the position of the child. The tumor was translucent. No constitutional symptoms indicating strangulation were present. We agreed upon a diagnosis of encysted hydrocele of the cord. The child was operated upon by the long incision and the diagnosis verified. A prompt cure followed.

*Case 4.*—Frank D., a traveling man, presented himself because of painful tumor in the left groin; gave the following history: About one year ago while carrying two large satchels felt sharp pain in the left groin. He continued his work during the day, but toward night the soreness and pain became so severe that he was compelled to give up his trip and go to bed. A physician was called, who made a diagnosis of omental hernia, and tried, without success, to reduce it. An operation was proposed, but the patient objected and it was never made. In a week or ten days the swelling opened and discharged pus. The patient was told that the omental portion and sac had sloughed, and that the process of inflammation had cured the hernia, but that great care should be exercised for fear of breaking down the inflammatory deposit, and that any return of the swelling should receive prompt attention, as so fortunate a result could not be depended upon to occur frequently. The abscess healed, but as

soon as the patient attempted to resume his business or move about more than in the most careful manner the swelling returned and the abscess would enlarge and discharge. As the patient was thoroughly impressed with the gravity of his condition he was constantly in fear of some serious hernial protrusion, and therefore feared to continue his business trips. An examination found an enlargement in the left groin and a small fistulous tract extending down into the substance of the swelling. The external ring was free, and showed no evidence of ever having been filled with a sac or closed by an inflammatory deposit, indeed the whole enlargement was in the subintegumental tissue. A diagnosis of inguinal abscess from suppurating inguinal gland was made, and the patient advised to have the indurated tissue removed and the fistulous tract dissected out. This was done, the wound healed readily, and no further trouble resulted.

*Case 5.*—Mr. B. was referred to me by Dr. R. Ludlam with the following history: Ten days before he had fallen while attempting to get into a buggy, and struck upon the step, receiving a severe blow in the right groin. The next day he noticed an enlargement in the region injured. A few days later Dr. Ludlam, who was calling at the house to visit a lady patient, saw him, made a diagnosis of inguinal abscess and advised a poultice. The patient, in the meantime, had made an application for indemnity to his Accident Insurance Company, and their physician called to examine him. He declared him to be suffering from a hernia, and, after a number of vigorous and rather uncomplimentary allusions as to the diagnostic ability of the members of a certain school of medicine, proceeded to reduce the hernia. This he claimed to have succeeded in doing, although there was no change in the swelling except an increase in the soreness and pain.

When I saw him the tumor occupied the right groin, and had somewhat the appearance of a direct hernia. Upon invaginating the scrotum the finger could be made to enter the external ring, which certainly was not filled with a hernial sac. At the same time the finger could be easily pushed under the swelling. The patient had a temperature of 102,

but no signs of strangulation. Dr. Ludlam's diagnosis was confirmed, and a fresh poultice was applied. A few days later the abscess was opened, and discharged freely. No hernial protrusion has ever taken place.

It is evident, from the cases related, that the mere presence of the tumor in the scrotum or at the site of the external ring is not in itself sufficient evidence upon which to make a diagnosis of hernia, however similar the tumor may appear to a hernial protrusion. Other and more rational symptoms are demanded, and, in the more obscure cases, systematic exclusion must be thoroughly employed before a reasonable diagnosis can be made.

The symptoms of hernia vary much, according to the nature of the protruded surface and according to the pathological changes which may have taken place after the protrusion.

In general the sudden appearance of a tumor at the abdominal ring, which is present when the patient is erect, disappears when he lies down, becomes larger and firmer on coughing, transmits a cough impulse to the fingers when the tumor is grasped, are sufficient reasons for making a diagnosis of hernia, but no one symptom can be depended upon as a certain and reliable test. Thus a varicocele, as in Case 1, increases on assuming the erect posture, disappears on lying down, and to the touch may resemble the inelastic, flabby feel of a omental hernia, but the occlusion of the hernial ring by the finger does not prevent the return of the varicocele, as it does the hernia, indeed the obstruction to venous circulation thus produced increases the size of the varicocele.

Any fluid lying within the influence of the abdominal muscles, as psoas abscess, or abdominal abscess, might increase on standing, decrease on lying down, be capable of being pressed back, or transmit the cough-impulse, and yet present other evidences that would enable a correct diagnosis to be made. Thus, in Case 2, all the common signs mentioned were present, but there was in addition to these unmistakable evidence of another disease to which all these symptoms might

be attributed, and which, considering the condition of the child, was probably the real cause of all the trouble.

A hydrocele, as in Case 3, might simulate an irreducible hernia, or appear to be reduced when it was not, but in the latter instance the return of the tumor, no matter what the position of the patient, and in the former instance the history, the circumscribed firmness of the tumor and its translucency were all in favor of a hydrocele.

Certain abscesses, as in Cases 4 and 5, may by their sudden appearance, their pain, their location and the general disturbance produced, resemble an inflamed hernia, but when the finger enters easily into the abdominal ring, and the swelling is only felt above the abdominal muscles, doubt as to the nature of the trouble need not be long entertained.

*Discussion.*—DR. E. M. P. LUDLAM—In regard to Case No. 3 of the paper, I am glad to report that the child is running around and doing very well.

DR. S. LEAVITT—In speaking of hernia I was reminded of a case which I took to be a hernia in an infant, but which turned out to be something else. It proved to be hydrocele of the cord. I have seen several cases since that time, and believe that they are by no means infrequent.

DR. R. LUDLAM—I am glad that so practical a subject has been brought before us. It is not always an easy matter to diagnose an inguinal hernia, and such a diagnosis involves a point upon which a good deal depends. In the treatment to be adopted it makes a vast amount of difference whether or not we have recognized the real condition. To put a truss upon an inguinal abscess, or to make a free incision into an inguinal hernia, might occasion serious mischief, and would cover the practitioner's reputation with a cloud. I might resent the insult referred to in Case 5 of the report, by advising the medical examiner of that insurance company to take a post-graduate course in the "Old Hahnemann," and brush up his own gifts in diagnosis, but perhaps it is not worth while to do so.

DR. G. A. HALL—I regret that I did not hear the reading of the paper, but if I am not too late I would like to say

a little about hernia. The study of a hernia is like the study of a fracture—the classical indications are not always present, and when they are present they may be complicated with a good many other conditions. There is a class of incomplete inguinal hernias, which I call *masked* hernias, where the ordinary signs of hernia are lacking, and they are frequently treated for something else, viz.: bilious colic, ovaritis, orchitis, cystitis, etc. Even the pain complained of may be referred to a distant organ or part of the body. If you take the history of the case you do not find the evidences of inflammation, or its method of development. On the contrary you find the history of the sudden onset of pain from an extra exertion.

Even the position of the patient is diagnostic; he is tied up in a knot, with the knees drawn up to the chin, and the hands clenched, lying upon the side, never upon the back. If you will take the history of the case there is no need for a surgeon of experience to prevent mistaking an inguinal gland for a hernia.

DR. SHEARS—Although the cases reported by me were confined to those in which hernia was simulated by some other disease, the discussion, I am glad to see, has taken a somewhat wider range. Dr. Hall's remarks upon masked hernia, and hernia simulating other troubles, are especially interesting. Several cases illustrating his remarks have recently come under my observation, of which the following may prove interesting:

Was called in haste to see Mrs. B., who was said to be dying. Found her suffering from terrible pain in the region of the stomach. She was lying in a semi-recumbent posture, covered with a cold sweat, and uttering cries of pain. She paid no attention to questions regarding her pain or its causes, but cried continuously for relief. From her family I learned that this pain had come on her suddenly while at her work, and apparently without cause. The first thing complained of was pain, which was soon followed by vomiting. She had had a natural movement of the bowels a short time before the pain commenced. It was midway between the



menstrual periods. The distracted state of the patient and friends prevented further inquiries, and a hypodermic injection of morphia was administered. After the patient had obtained relief a more careful examination was made, and a small femoral hernia discovered. The protrusion was readily returned. The patient now told me she had had similar attacks, although not so severe, many times during the past year, and the last six months they had been quite frequent. She had been told, and believed the attacks due to some uterine trouble. Rest in the recumbent position had previously afforded relief. She had never thought of any relationship existing between the little tumor in the groin and the pain in her stomach. A truss was fitted, and so far the patient has had no return of the pain.

COMPOUND COMMINUTED FRACTURE OF THE TIBIA.—REPORTED BY DR. G. A. HALL.—*Case.* Patrick K., aged twelve years. In the early part of June, while this young man was attempting to mount a horse, the animal became unmanageable, threw him to the ground and stepped upon his right fore-leg with the cork of the shoe, causing a punctured, compound comminuted fracture of the middle third of the tibia. The boy was put in the care of an "army surgeon," who continued in charge of the case up to September 15, when he was brought to the Chicago Surgical Institute for treatment.

Upon examination we found there had been imperfect union. On the surface was an oblong, open ulcer about three inches in length and one and one-half inches in width, with deep purple borders, fading out into the adjacent tissue. From this ulcer was issuing sanious bone-pus mixed with small exfoliated particles of bone.

An incision was made through the integument, commencing two inches above the upper border of the ulcer, and extending downward and around, so as to include the free margin of the ulcer on either side; then it was continued down in a straight line two inches below the lower border of the ulcer. The entire unhealthy granulating mass was removed, and the softened bone-tissue was chiseled out com-

pletely. Osteo-myelitis had existed, and extended up the shaft and down toward the ankle. Fragments of the posterior wall of the tibia overlapped the upper fragment, and had formed attachments to it. The cavity presented a solid wall, but the bone-tissue was of a dark yellow or gray color, and was apparently devitalized. Knowing how rapidly bone-tissue, in such young subjects, will become restored if all the circumstances are favorable, we concluded to dissect up the integument on either side, bring it forward, unite it with wire sutures, and thus cover up the cavity and all the bone-tissue. A bone drainage tube was introduced, the wound was dressed antiseptically, and was not disturbed for three days. When the stitches were removed the integument was firmly united by first intention. At the second dressing evidence of sphacelus had set in, and we began to weaken in our confidence of saving the limb.

The tar plaster was now applied, and we were gratified to find at the end of the seventh day that the inflammatory action had become healthy, and granulations began to spring up. The flaps had parted, leaving the bone exposed in the center. We were pleased, however, to see the capillary circulation of the bone restored, and at this date we have every reason to believe the bone will be restored, and that the limb will be a useful one.

One object in reporting this case is to note the difference between young and old subjects in the process of bone-repair. Under like circumstance, in a man fifty or sixty years of age, we should hardly have hoped to save the limb, as at the time of the operation the boy was suffering from absorption of long standing. His temperature ranged all the way from 100° to 102°, and he suffered with slight rigors, and was pale and emaciated in appearance.

The second object is, that it is almost impossible to make nature cover a piece of dead bone. If indeed we should succeed in covering it for a short time, and feel that we had accomplished our purpose, sooner or later ulceration would undo the work. In this case the evidences of mortification were due to the fact that nature rebelled against covering a

diseased bone. The timely application of the tar plaster aided the work of nature and gave an opportunity for the capillary circulation to be established. This being done, nature was then willing to go on with her good work and fill in the entire cavity by healthy granulation. This will become converted into fibro-cartilaginous tissue, which will afterward take on the process of ossification.

Our third object is to call attention to the carelessness of the first surgeon in not cleansing the wound of foreign matter and removing the spiculæ of detached bone. Had this been done and the fracture properly dressed the subsequent result would have been avoided.

*Discussion.*—DR. SHEARS.—The case just reported illustrates the wonderful reparative power there is in the bone tissue, especially in young children. We are all familiar with the almost magical results obtained in operations for the removal of deformities, or in the treatment of accidents in which the soft tissues are involved, but it is not so generally known that, in favorable cases and under proper precautions, almost similar results may be obtained in bony tissue. An interesting case showing the possibilities of the transplantation of bony tissue was reported by Prof. Poncet to the French Surgical Society in 1886, and his experiments have been repeated by many others, with some successes and many failures. Mr. Poncet's case was as follows: From a young boy, eleven years of age, the entire tibia, except the upper articular surface, had been removed on account of extensive necrosis. The periosteum remained more or less altered in the upper half, but in the lower half was entirely destroyed. Some two weeks later, while the wound was granulating, Mr. Poncet placed in the midst of the granulations in the boy's leg, seven or eight little pieces of bone about three-fourths of an inch long, which he had removed from the humerus and tibia of an infant, which had died immediately after birth. Of the implanted pieces four became fixed, and around them new bone began to form. No more human grafts being obtainable, twelve grafts were sliced from the tibia of a young and rapidly growing kid, and placed as before. Eight of these re-

remained adherent, and became the center of new bone formation. In time the leg healed and the boy had a firm, solid tibia. It is only just to add that more failures than successes have resulted in the attempts which have been made by others to duplicate this case, but the possibilities of advancement in this direction are still great.

**A CASE OF SUB-COSTAL ABSCESS.—BY DR. W. A. DUNN.—**  
*Case.*—Mrs. Mary E., a rather delicate lady of 62 years, while cording an old-fashioned bed, four years ago, slipped and fell, striking her side against the foot-board. She sustained considerable shock, but was herself again in a few days. Nothing more was thought of the fall until a year ago. She had suffered since the fall with pain in the left side of the chest, extending upward to the side of the neck, and also had a quick, sharp cough.

About a year ago she complained of severe pain in the left costal region; a small tumor appeared in the seventh intercostal space, about four inches from the median line. The tumor steadily increased in size, and gave her so much pain that she consulted us in regard to it. I lanced it about six weeks after it was first felt.

As the ribs were perfectly smooth to the touch we took it to be a simple abscess, but as it did not heal after a month, my partner, Dr. Frank Baker, under whose care she remained while I was in Vienna, opened up the cavity in order to get rid of the pyogenetic membrane and diseased rib, if any was discovered. He found, however, that the pus came from under the ribs through a very small opening, and that it was quite impossible to reach the seat of the trouble. Nothing more could be done in an operative way, the discharge continued, as well as the cough, and some pain. The most troublesome symptom was an incessant nausea, and vomiting whenever she would cough, hence she was quite unable to retain any food. She had a number of septic chills, and always had a little fever.

Her death occurred about eight months after the appearance of the external tumor. On post-mortem examination we found the third, fourth, fifth and six ribs very friable and very much of the bony substance absorbed, so much so that one could easily crush them between the fingers.

Beneath the ribs, and extending from the second rib above to the seventh below, and from the sternum in front to five inches posteriorly, was a solid plate of bone deposit about three

lines in thickness and very rough on both surfaces. It was not firmly attached to the ribs, but deposited against them. This plate of bone formed the external wall of an abscess, the inner wall of which was formed by the pleura and pericardium. It had burrowed downward until it came to the diaphragm, when fortunately it found an outlet between the ribs and was opened externally.

It seems remarkable that such a large, rough surface could be in contact with the pleura and pericardium and not cause a fatal inflammation long since. It is a question if the fall was the real cause of the deposit, as there is no sign of a fractured rib; besides the deposit is not a part of any rib, and is everywhere separated from them by the periosteum.

**THE LATEST ECHOES ON TUBERCULOSIS.\*—By B. S. ARNULPHY, M. D.**—Every practitioner is aware of the difficulties that attend the early diagnosis of tuberculosis, and has often felt the weight of the responsibility involved. Any addition, therefore, to the signs already known, ought to be gratefully received.

Among the clinical hints presented to the consideration of the congress, in that line, those due to the experience of Dr. Espina y Capo, of Madrid, certainly come foremost. He believes that a careful and systematic study of the dimensions of the thorax will, in most instances, yield valuable information, not only in the confirmed stages of the disease, but in that of morbid imminence. Given an individual between adolescence and declining age, if the thoracic circumference be to any considerable extent less than half the height of the person, the doctor claims it to be a sign that will warrant suspicion. In addition to this, should the maxillary circumference be below 74 cent. (about 29 inches) the axillary one below 72 cent. (28.5 inches), and the xiphoid one below 78 cent. (31 inches), especially if the distance from one nipple to the other be less than 17 cent. (7 inches), it were idle to doubt any longer.

Another useful means of identifying tuberculosis is the thermometer, above all in those cases where an acute development is liable to occur. The tracing of the thermometric

\*Continued from page 329.

erve is so characteristic in this terrible disease that it seems strange to see so few physicians able or willing to avail themselves of this precious instrument as a means of diagnosis in obscure cases. It is a bit of sound practice, as soon as tuberculosis is suspected, no matter by what sign or symptom, to use the thermometer, an evening rise indicating  $102^{\circ}$  to  $104^{\circ}$  will give a strong presumption of tubercle. If such rise is repeatedly observed in connection with a morning remission of two to four degrees, neither malaria or suppuration being present, all doubts are solved.

My personal experience is strictly in accordance with these statements, but I think that further observation is needed before what the Spanish doctor has to say about the sphygmograph will receive a general endorsement. We all know the frequency of hemoptysis in incipient tuberculosis, but we also know how guarded the family physician's statements have to be as to the prognostic value of that ominous symptom, when the physical signs are undeveloped, when the disease is yet in its anæmic stage, and when its seeds are growing insidiously but have not yet been expelled with the products of a free exudation. It is this condition that baffles analysis and leaves the problem an open one.

If it were demonstrated that in every case of bloody broncho-pulmonary exudation due to tuberculosis the sphygmograph were to faithfully exhibit the tracing of a peculiar diastolic dicrotism, as the doctor points out, we would undoubtedly be possessed of an invaluable differential sign; but every one who is practically acquainted with the sphygmograph is aware that the indications which it furnishes are not always reliable, and that the slightest disturbance of pressure in the arteries is apt to create more or less dicrotism. In fact, by lowering the blood-pressure, any kind of hemorrhage is bound to bring about transitory dicrotism. *Sub judice lis est.*

When compared to the rich harvest of facts gathered in the field of etiology and pathogeny, by the members of the Congress, what the therapeutics have to boast of is comparatively meagre. Mr. Legroux extols the methods of intra-respiratory applications by means of the inhalation of an atmos-

phere saturated with vapors of *Creosote*, which, he says, paralyzes the bacilli, and modifies the local putrefying process, which, no doubt, causes the hyperthermic exacerbations in the evening.

Belgian practitioners show a great confidence in the properties of *Iodoform*, and *Turpentine* has found a warm advocate in Dr. Brimont. Dr. Raimondi says some good things of the wonders of *Fluorhydric acid*. Both of these agents are used by inhalation, and good reports are heard of their action on the bacilli.

On the plea of the so-called sterilization of the blood, Dr. Routtel has evolved a treatment of which subcutaneous injections of *eucalyptol* and *arseniate of strychnine* are the leading features.

Dr. Luton (of Reims) furnishes a very elaborate paper on the value of the *copper salts*, especially the phosphate, as a means of arresting the evolution of tuberculosis in its initial stage. He believes the action of the copper salts to be distinctly of the zymotocidic order. The facts adduced in support of his argument wear the aspect of unsophisticated truth. Experience will soon show whether there is more in this method than in that of Bergeon, with his rectal gaseous enemas. Poor Bergeon! Why did the congress snub him? His very name failed to be mentioned in the record of the proceedings of this congress on tuberculosis.

Less sanguine of the good results of therapeutical interference are Drs. Daremberg and Fremy; and I have no doubt the majority of the congress were of the same mind. They report most favorably upon those "closed establishments" (of which that at Falkenstein is an example), where the patients are subjected to continuous rest, night and day, under the combined influence of a constant supply of fresh air at a uniform temperature, and of a strictly hygienic regimen. One-fourth of the patients thus treated are restored to health.

*Apropos* of diet, the raw-meat cure, which a few years ago, and even now at the hands of some physicians, is so much in favor, seems to be pretty generally acknowledged as a grievous mistake. Besides being liable to infection from

macilli, raw meat is very poorly calculated to bring about the formation of adipose in the tissues of the tuberculous subject, since jockeys have to resort thereto when they want to reduce their flesh. The fatty, hydrocarbonates are much better suited to the purpose, especially if this diet is intelligently varied and made palatable by proper seasoning. Our friend, Dr. Cousset (of Paris) has advised that judicious course ever since he became a clinical teacher, and this is no small credit to his well-known skill and ingenuity. I remember having seen a good many cases which he had under treatment at the "Hospice of St. Jacques," as far back as 1874, and which were steadily improving, gaining flesh and strength, under a strict starchy diet. The doctor had observed that phthisis is a very rare visitor in those monastic institutions where the rule prohibits the use of flesh. What his keen eye had detected more than two decades ago is now emphatically recognized by the other lights of the profession.

Strange to say, even in the field of tuberculosis, surgery seems to get ahead of her stately sister, Therapeutics; and stranger still, Spain deserves to be cited as the country where surgical intervention has displayed the greatest activity in the treatment of many forms of localized tuberculosis, even in the lungs and the brain. For being less bold our French surgeons have perhaps obtained more satisfactory results.

From the statements of such authorized men as Verneuil, Redard, Richelot, Barette, etc., we gather that it is good practice to attack and destroy, whenever accessible, all ganglionic and osseous formations of this kind. During the past ten years, in the case of children, Verneuil has not once resorted to a resection proper for osteo-arthritis affecting the wrist, the forearm or the tibio-tarsal region. When the joints present a very pronounced swelling the injunction is to open them, to scrape the fongosities and abrade the diseased bones, freely using the thermo-cautery. If proper antiseptic measures be adopted, with good drainage, and the iodoform dressing, and protracted antiseptic baths locally applied, the wound will heal nicely, the functions of the limb will be



preserved, and generalization of the disease prevented by this timely destruction of the focus.

It would be an error to think that surgical interference in those cases favors auto-inoculation; on the contrary, the local focus, if left to itself, will, in time, involve infection, a sad result that may be averted in almost any case by resort to modern surgery.

If every friend of the human race has ample reason to rejoice over such achievements, the guinea-pigs and their friends have still greater reason to mourn. Owing to their peculiar susceptibility to bacillary infection, these unfortunate little quadrupeds have had conferred upon them the doubtful and dangerous honor of being considered as the "living test" for tuberculosis. It is a deadly tribute that they pay for this distinction. Henceforth the fashion will be to resort to the guinea-pig test, not only as a ready clinical means of solving the diagnosis of doubtful cases of pulmonary tuberculosis, but also for the purpose of identifying the nature of some suspicious abscesses, adenopathies, subcutaneous gummata, or mucous ulcerations, fistulæa, synovites, purulent urine, or even in some cases of visceral alterations, such as epididymitis, etc., etc.

It is argued, and with perfect plausibility, that the microscopic search for the bacillus is tedious and uncertain, therefore anything but clinical, whereas the guinea-pig test is easy and unfailing. The only thing you have to do is to get hold of one of the little martyrs, to shave its belly, and to thrust into it a "pipette de Pasteur" previously sterilized and loaded with the suspicious product. In the genuine cases you will find after ten or twelve days that the peritoneum is affected by a confluent eruption that extends to the liver and spleen. This settles the question. And it goes without saying that the same test is available for the diagnosis of such visceral and ganglionic affections of the cattle which are suspected to be tuberculous, and can thus be highly serviceable.

Besides the many valuable points made by the Congress three immediate practical results have been obtained, which

are worth mentioning: (1.) The French government, mindful of its obligations to the people, and as a token of deference to the authority of the Congress, has had bovine tuberculosis inscribed among the infectious diseases. (2.) Slips and pamphlets have been distributed all over the country, giving to the people, in a simple and concise way, the proper directions in order to avoid tuberculous infection through the use of meat and milk, as well as for the destruction of the germs in contaminated vessels, clothes, bedding, etc. At the same time the local authorities have been instructed to enforce all such precautionary measures as will be advised by the regional boards of health. (3.) Under the auspices of the Congress large sums of money have been subscribed that will go toward erecting two great sanitariums, to be fitted with the best modern appliances, where the children of poor tuberculous parents will be taken care of until they reach adult age.

This last and highly commendable project is the direct outcome of the interest which the Congress has awakened on the surface of the fatal indifference of the people as regards phthisis. We prick up our ears at the very name of small-pox and scarlet fever; and that of cholera or yellow fever sends a chill through our marrow; but we feel safe with the hidden foe that plays more havoc around us than ever did any dreaded plague. To the thoughtful mind this apathy of the public toward such pressing danger is one of the social wonders of the times in which we live.

For any one who forms a clear idea of the paramount importance of the point at issue, it stands to reason that if the only outcome of the Congress had been to determine the infectious nature of tuberculosis, it alone would merit the unqualified approval of mankind. But it has done more. It has gone deep into the redoubtable problem of the eradication of the scourge, and brought to light such landmarks toward that end as bid fair to be conducive to its solution in the near future. Nor is this all. There is still more good in store for humanity in the idea that originated the Congress. It is the ambition of the leading spirits of that institution—for it is not going to die—to follow up the study of all virulent diseases until they are finally stamped out. Of the many signs that bespeak the regeneration of France this is the noblest. Let us hope that she will prove equal to the task that she has set for herself.

## Hospital Notes.

### THE GYNECOLOGICAL CLINIC.

#### SERVICE OF PROF. E. S. BAILEY.

In presenting the three following cases latent gonorrhœa in the female is the topic:

*Case 1.*—PELVIC CELLULITIS.—Mrs. W., aged twenty-four, came to the Hahnemann Hospital, of Chicago, in April last. She had been a bed-ridden invalid for a year, and was with difficulty removed to this city. The first part of the clinical history given was that she married quite young, had three living children, and has had one miscarriage. She dates her illness to the bad effects of the miscarriage. The mishap was followed by an acute attack of pelvic cellulitis, resulting in abscesses, profuse discharges of pus, pyæmic absorption, extreme prostration, emaciation, and in addition she has acquired the morphine habit.

The second part of the history was voluntarily offered a little later, and reads: the miscarriage was a voluntary criminal abortion, produced by her own hands with a wire twisted from a tin pail, the fœtus being three months old. The reason assigned for the act was that her husband had returned to their home, after a few weeks' absence, in a badly diseased condition (gonorrhœal). The knowledge of the fact angered her, and scarcely knowing how, she managed to get rid of the contents of the uterus. Her convalescence was tardy, but without inflammatory sequelæ. Marital relations were not resumed until her husband had obtained a certificate of cure from a local physician. Immediately following a single coitus acute gonorrhœal symptoms were present in a violent form, and vaginitis, metritis—ovaritis appeared in order and rapidly. She has always questioned the correctness of the cure, as given in the easily-obtained certificate. Her long illness followed. The present conditions are, the more or less constant discharge of pus, per rectum, the anchorage of the pelvic viscera by adhesive inflammation, dysmenorrhœa, in-

ability to stand or walk for any length of time, and irritability of the stomach; pain, paroxysmal and very exhausting, present some of the time each day, and often at night preventing sleep.

During her stay in the hospital she was, physically, much benefited. The treatment consisted in the use of local applications of heat and cleansing douches. *Hepar sulph. Cantharis*, and *Silicea* in the 6 were the remedies.

*Case 2.*—SUB-ACUTE PELVIC PERITONITIS.—Mrs. E., aged twenty-eight, admitted to the clinic April 7, 1888, complains of a constant burning pain in the region of the left ovary, a dragging back-ache, dysmenorrhœa and painful micturition. She says that for two years she has not been free from intrapelvic pain. Her symptoms are constantly aggravated by having to carry the coal and household provisions up two flights of stairs, the care of her three children, the youngest of which is four years old, and of her worthless husband.

Physical examination gave unmistakable evidence of sub-acute pelvic peritonitis of the left side. She suspected infection from her husband, whom she had known to have had frequent attacks of gonorrhœa for several years past, to be the cause. His habits are those of a common drunkard.

In the treatment she obtained the greatest relief from *Bell. 3*. At the last clinic, September 28, she reports herself as improved in every way, and intends to get several hundred miles away from her husband, and remain away, this being an essential part of our prescription.

In regard to the diagnosis of pelvic peritonitis, according to Winckel, "it may be applied to a circumscribed spot, or signify co-existence of perimetritis, perosalpingitis, perioophoritis, pericystitis and periproctitis." There is no question of doubt as to the infectious nature of her disease, which we may well say is a chronic gonorrhœa.

*Case 3.*—DYSMENORRHŒA.—Mrs. B., aged twenty-eight, mother of one child now eight years old, had a miscarriage nearly a year ago. She came to our clinic but once and requested a private consultation (August 6). Present condition vaginitis, vulvitis and a torturing, burning pain in the blad-

der, frequent urination with tenesmus tenderness, and at times extreme pain in the region of the left ovary. Sometimes a tumor the size of a large lemon, she says, can be distinctly outlined in the left ovarian region. The dysmenorrhœa is not unlike labor pains, oftentimes, and she is sick for a week. She could not assign any reason for the miscarriage; says the present conditions, she thinks, are due to the fact that she has been in the habit of using clear vinegar as a vaginal injection to prevent conception. She is troubled greatly with an acrid leucorrhœa during the inter-menstrual period.

*Kreosotum 3* was advised, and plain hot water vaginal injections.

The husband, finding that she had gone to a clinic, came to our aid with the following additional history: He believed he had communicated to his wife the gonorrhœal virus which had been the cause of so much of her suffering. His report was that some three years ago he had the gonorrhœa, and to his dismay he had never been entirely cured. It would return again and again. The wife, he thought, had had her present illness, though not so severely, for two years past.

In presenting these brief notes, taken from the records, my object is to refer to this form of suffering in women, due to specific infection, its latent nature and its chronic course.

In men the disease is known to attack the urethra, the testicles, epididymis, and to be a factor in rheumatic affections. As to its chronicity, recent reports,\* based upon a critical record of fourteen hundred cases, contain the following summary: "(3) The abortive treatment is ineffectual and harmful." "(5) We recognize in the disease a marked tendency to persist in the chronic stage; (6) the tendency to become chronic and to persist appears to be increased by the use of topical treatment in the first and second stages; (7) the so-called methodical treatment, that is the internal administration of remedies, combined with the proper hygienic and dietary regulations, does most to shorten the disease." In the female the frequent escape of the urethral infection, the

\*See the *Medical Record* for September 22, 1888, page 326.

similarity of the discharge to that of vaginal catarrh or leucorrhœa, the absence of severe acute or lasting local symptoms, have given some occasion to lessen the importance of the gonorrhœal infection. In the Fallopian tubes and ovaries no better hiding-place for gonococcus could be imagined. Could these organs be within reach of poultices, suspensory bandages, and other direct applications, at the proper time, much of the severity of these cases would be remedied, and possibly the chronic nature shortened. Fifteen years ago (1873) Dr. Noeggerath published a paper on "Latent Gonorrhœa in the Female Sex," in which he says: "I have undertaken to show that the wife of every husband, who, at any time of his life before marriage, has contracted a gonorrhœa, with very few exceptions, is affected with latent gonorrhœa." \* \* "I believe I do not go too far when I assert that of every one hundred wives who marry husbands who have previously had gonorrhœa scarcely ten remain healthy." The diseases to which this author refers as remote consequences of latent gonorrhœa are perimetric inflammations, both acute and chronic ovaritis and catarrh of the genital tract. The same author, in March, 1888, says before the section for Dermatology and Syphilidology of the German Naturalists:\* "In large and middle-sized cities gonorrhœa is the most frequent disease occurring in the female sex." \* \* "The diagnosis of gonorrhœa in the female with acute attacks (acute and recurrent perimetritis) is not difficult if one takes into consideration the ætiological events, and also finds a salpingitis." It may seem difficult to accept the extreme views of this author. It is hard to condemn the female sex to so much of suffering, and of such a nature. Van Buren and Keyes say: "Gonorrhœa sends more to the tomb than syphilis," and Prof. Eastman adds, "It is my belief that this same foul virus (gonorrhœa) sends twice as many women to the grave as men." With the views of more recent investigators coming to the front, and sustained by most careful observations, it is not untimely for us to declare that the teaching heretofore extant, that gonorrhœa in the female is less serious than in the male, is mischievous and wrong, and that this portion of our literature *must be reuritten*, and a greater importance attached to this disease.

\*Annals of Gynecology, September, 1888, page 582.

## Miscellaneous Items.

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Through an unfortunate oversight the members of the Inter-Collegiate Committee of the American Institute were not all present at the opening of the "Old Hahnemann" for the session of '88-89.—Prof. Fellows is about again after a slight attack of lumbago.—Prof. Bailey has a new horse and buggy, Prof. Hawkes a coupé, and Dr. W. P. McCracken a bouncing boy baby.—Dr. D. S. Smith is president of a veteran club of 300 that voted for Tippecanoe and Hahnemann too, in or about 1840.—The *bona fide* students on the benches at the opening lecture by Prof. Halbert numbered 178, "and still there's more to follow."—Everybody enjoyed Prof. Hall's big-hearted speech, story and all, at the College Reception.—Death has claimed three more of our most valued friends: Dr. O. P. Baer, who died of tuberculosis at Richmond, Ind., August 18, æt. 72; Dr. D. J. McGuire, of the same disease, at Pasadena, Cal., August 18, and Dr. Wm. Von Gottschalk, at Providence, R. I., Sept. 10, æt. 62.—Readers should remember that the meetings of the Clinical Society will henceforth occur on the last, and not the first, Saturday in the month.—The Bureau of Diseases of the Eye and the Ear, Prof. Vilas, chairman, will report at the October meeting.—Our thanks are due to its distinguished head for a beautiful copy of the Second Annual Report of "Helmuth House," 41 E. 12th Street, N. Y.—Prof. J. P. Cobb opened his course on Physiology with a lecture that merits publication, and makes us regret that the CLINIQUE is not twice as large as it is.—Prof. Gee has returned from Colorado, ditto Bro. Ballard, in improved health.—Prof. Crawford's papers on the Climatic Treatment of Disease will be continued in our next issue.—Prof. Dunn has an office at Nos. 16 and 17 Central Music Hall.—Prof. Arnulphy has removed to 88, 53d St., Hyde Park.

# THE CLINIQUE.

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## Original Lectures.

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A CLINICAL LECTURE DELIVERED AT THE HAHN-  
EMANN MEDICAL COLLEGE AND HOSPITAL.

BY PROF. W. J. HAWKES, M. D.\*

*Ladies and Gentlemen:* This is the first regular medical clinic of the present term. These clinics are conducted through the whole year. During the vacation of the professor in charge they are under the care of the house physician and hospital internes. Many of the cases presented here to-day are those who have been here before and prescribed for by the house physician. The house physician and internes are graduates of this institution. They have been trained in prescribing as taught by Hahnemann, and strictly in accordance with the homœopathic law. It may be well in the beginning of our course to outline this manner of prescribing.

Homœopathy being a science under a natural law, the physician knowing all knowable of his profession takes each step with as much accuracy and confidence as does the practitioner of any other science, with the difference against the practice of medicine that there are many opportunities for error, owing to man's imperfect nature, not encountered in the exact sciences. The gatherer of the herb from which the drug is made is imperfect. Mistakes may occur in the preparation of the drug from the plant. The prover may

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\*Reported by William Whitford.



blunder through ignorance, or may willfully deceive; the patient may give an incorrect history of his case; the physician may make an incorrect diagnosis of the disease and remedy; so that there exist so many opportunities for error the science of therapeutics is to that extent less exact than other sciences.

In proof of the claim that Homœopathy is a science, I will undertake, as the patients are presented before us to-day, to tell the remedy that has been prescribed in each case where the patient has been positively benefited, without my having previously had communication with the patient or house physician in regard to disease or remedy. I will also undertake to indicate the remedy which has *not* been prescribed in curable cases where no improvement has resulted.

Our prescriptions are made upon the totality of the symptoms. The meaning of the "totality of the symptoms" is not generally correctly understood. There are those to-day teaching and practicing medicine who claim that the totality of the symptoms is the sum of the morbid phenomena presented by the patient as he appears before the physician; that it is unnecessary to inquire into his family history, his habits or modes of life, his social and business relations, or any other question that might affect his physical condition. This is incorrect. The totality of the symptoms embraces every fact, whether hygienic or pertaining to heredity; whether of mode of life or any other external circumstance or condition that would tend to affect the health of the individual, in addition to the morbid phenomena presented by the patient, which includes the subjective symptoms, as experienced and related by the patient, the objective symptoms, as observed and detailed by friends or nurse, and those observed by the physician himself—in short, every fact past or present that will throw light upon the cause or character or location of the patient's morbid condition. It includes also the organs and tissues affected, the influences, whether of time or circumstance, aggravating or ameliorating the patient's distresses.

Those who claim that the totality of the symptoms includes only the observable morbid phenomena in the patient at the

time of examination, to the exclusion of all other facts, claim Hahnemann for authority ; they claim to be Hahnemannian prescribers and practitioners. The claim is unfounded, and does injustice to the immortal discoverer of the law under which we practice.

Hahnemann says : "The physician should distinctly understand the following conditions : What is curable in diseases in general, and each individual case in particular, that is, the recognition of disease. He should clearly comprehend what is curative in drugs in general, and each drug in particular ; he should possess a perfect knowledge of their medicinal powers. He should be governed by distinct reasons in order to insure recovery by adapting what is curative in medicine to what he has recognized as undoubtedly morbid in the patient ; that is to say, he should adapt it so that the case is met by the remedy, with much regard of its kind of action, its necessary preparation and quantity, and the proper time for its repetition. Finally, when the physician knows in each case the obstacles in the way of recovery, and how to remove them, he is prepared to act thoroughly and to the purpose ; he is a true master of the art of healing. *The physician in curing derives assistance from a knowledge of facts concerning the most probable cause of acute disease, as well as the most significant points in the entire history, especially in the case of chronic disease.* Aided by such knowledge, he is enabled to discover the primary cause, the latter depending mostly on a chronic miasma. In connection with this the bodily constitution of the patient (particularly if he has chronic disease) ; the character of his mind and temperament ; his occupation ; his mode of living and habits ; his social and domestic relations ; his age and sexual function, are to be taken into consideration. The unbiased observer sees in each individual disease only what is outwardly observable through the senses ; the many changes in the sensorial condition of body and soul—morbid signs or symptoms—in other words, he observes deviations from the previously healthy condition of the patient, felt by him and recognized upon him by his attendants, and observed upon him by the physician. All

these observable signs together represent the disease in its full extent, that is, they constitute together the true and only conceivable form of the disease. In a disease not presenting any manifest exciting or maintaining cause for removal, nothing is to be discerned but symptoms; these alone, with due regard to the possible existence of some miasma, must constitute the medium through which a disease demands and points out its own curative agent. Hence the totality of these symptoms, this outwardly reflected image of the inner nature of disease, must be the chief and only means of the disease to make known the remedy necessary for its cure, the only means of determining the selection of an appropriate remedial agent. In short, the totality of the symptoms must be regarded by the physician as the principal and only condition to be recognized and removed by his art in each case of disease, that it may be cured and converted into health."

The immortal Carroll Dunham says: "It is an objection often urged against Homœopathy, that as a system of therapeutics it dispenses with the necessity for diagnosis. We profess to prescribe according to the totality of the symptoms, but by this we are far from meaning to imply that each symptom is considered and prescribed for independently of all the other symptoms. On the contrary, while on the one hand every symptom must be taken into consideration as indispensable to a true picture of the disease, hence in this view no one symptom can be said to be less important than another; yet, on the other hand, the symptoms vary among themselves; some are primary or idiopathic, others are reflex or sympathetic. The latter are as important to a true picture of the disease as the former. They are more important, not simply as symptoms, but as sympathetic symptoms. Now, to form a diagnosis is to distinguish from among the whole number of symptoms, idiopathic and sympathetic, attributing each symptom to be idiopathic or sympathetic of the organ or tissue, which, in reality, is said to form a just notion of the pathological condition of that organ or tissue. That it is necessary for us to make such a diagnosis before prescribing, follows at once from the rationale of homœopathic prescription. The

homœopathic practitioner having got a picture of the disease he is about to treat, i. e., having got the totality of the symptoms, proceeds to compare this picture with the pathogenesis of various drugs.

“ Now, these pathogeneses are themselves pictures of disease; they are symptoms of drug disease, and as such they are divisible into idiopathic and sympathetic symptoms. The organs or tissues in which they have their seat, and the pathological conditions of these organs, may be various. In seeking a drug whose symptoms shall correspond most nearly to those of the disease to be treated, it is evidently necessary to seek a drug, the idiopathic symptoms of which shall correspond to the idiopathic symptoms of the disease, and the sympathetic to the sympathetic—a drug whose symptoms of either variety shall have the same set as the analogous symptoms of the disease, and shall result from a similar pathological condition. But we cannot select this drug without having previously formed a diagnosis, not merely of the disease to be treated, but also of the various drug diseases, of pathogenesis that constitute our *materia medica*. This necessity may be illustrated by reference to errors in which a neglect of it leads us.

“ Spontaneous vomiting of bile by a child may be an idiopathic symptom, indicating abdominal derangement, or it may be merely sympathetic of cerebral disturbance. Several drugs produce vomiting of bile, some directly idiopathically by affecting the digestive organs; others by reflex or sympathetic action, their primary action being on the nervous centers. According to our diagnosis of disease in a child and of the drug disease, we should have under the one view *nuxvomica*, *ipecacuanha*, or the analogues, or under the other *belladonna*. Again, depraved appetite, convulsive movement, distorted vision, a peculiar aspect of distress may be an idiopathic expression of disorder in the nervous centers, or may be sympathetic with irritation produced by *entozoa*. In the one case, we should select a remedy which affects the nervous centers idiopathically, *belladonna* or its analogues; or, in the other, a remedy which acts idiopathically on the

vegetative sphere and affects the nervous centers sympathetically, as *Cina*. Neglect to distinguish between these varieties of symptoms has led compilers of manuals to recommend *Cina* in hydrocephalus.

“Moreover, it is requisite to determine the seat of the symptoms, both in the disease and in the pathogenesis. Pain and tenderness in the right iliac region, with local heat and fever, may have their seat in the cellular tissue, in the muscular or peritoneal layers in the caecum, or even at certain times in the ovary. So might similar symptoms in pathogenesis arise from a pathological condition of these various tissues. Evidently we cannot select our remedy with certainty of its adaptedness, unless we make a diagnosis both of the disease and of the pathogenesis of the drugs.”

It is evident from these unambiguous words of these two most brilliant men of our school that both classes of extremists, those who, on the one hand, exclude from their totality of symptoms everything excepting the symptoms presented by the patient before them, and, on the other hand, those who base their prescription upon a certain presumed diseased condition, are equally at fault. It is true also that the physician who bases his prescription upon the symptoms presented by the patient before him to the exclusion of all other considerations, has a much greater probability of making a correct selection than he who bases his upon what he regards as the pathological condition alone, to the exclusion of the characteristic and peculiar morbid phenomena presented by the patient. The former has, at least, the positive symptoms experienced by the patient and observed by himself in the form of pain, etc., upon which to base his prescription. He who is guided by the pathological condition alone has only an invisible deduction drawn from the positive morbid phenomena and projected into the patient; for diagnosis of a pathological condition is made in the same way as that of diagnosis of the pathogenesis of a drug, viz., *by the symptoms*.

Our chief aim in the medical clinic will be to make a correct prescription in each case without entering into a

thorough physical examination; under the circumstances it is plainly impracticable to make an accurate physical diagnosis of each case before the whole class. There are sub-clinics in which accurate diagnoses will be made to small classes; consequently our chief object will be to make a correct prescription in each case. Our sole object will be to learn and teach as much as possible. No hobbies will be ridden; no pre-conceived notions on disputed subjects will be discussed; the prime object will be to select the remedy homœopathic to each case. In cases where the remedy is unmistakably indicated, we will test the various potencies. We all know that the low potencies operate; a great part of the success of our school has been accomplished by the use of low potencies. Comparatively few of us, however, have faith in the active curative power of the higher potencies, consequently, in cases where we are positive that a certain remedy is indicated, we will prescribe the higher potencies with a view to ascertaining if they are or are not actively curative. In cases where we are uncertain as to the accuracy of our selection, we shall use the low and the high, a dose of the low in the morning, and a dose of the high at night, for three days.

This course becomes almost a necessity when you know that a great majority of your preceptors have no faith in any potencies higher than from the third to the sixth, and who never use any preparations above those figures; that there are men prominent in our school, who, while they concede that the microscope discovers drug material up to the 12th potency, deny the possibility of its existence, and consequently of its action, in preparations beyond that point; and that there are others equally successful and equally conscientious who assert that there is evidence of active curative power in the 200th potency and upward. It will be no part of our course to advocate one or the other potency. We will "prove all things and hold fast to that which is good." When we consider that the microscope is not yet able to discover the point beyond which matter ceases to be divisible, and that every molecule possesses the properties of the largest aggregation of molecules, and when we consider that "there are one-hundred-

thousand-million-million-million molecules to a cubic inch of gas." it behooves us to speak modestly when we undertake to say of a certain drug that it ends here or it is not there. It is taught in Harvard College to-day that the chemist can weigh a molecule that corresponds with our 28rd decimal potency as accurately as the astronomer weighs the planet Jupiter and tells us that its weight is 384 times greater than that of our earth.

To quote from the chemical lectures of Josiah P. Cook, of Harvard College: "To the chemist, on the other hand, molecules determine those differences which distinguish substances. Sugar, for example, has qualities which we associate with that name, because it is an aggregate of molecules which have these qualities. Divide up a lump of sugar as you please, the smallest mass you can recognize still has qualities of sugar, so it must be if you continue division down to the molecule. The molecule of sugar is simply a very small piece of sugar; dissolve the sugar in water and we obtain a far greater degree of subdivision than is possible by mechanical means, a subdivision which we suppose extends as far as the molecules. The particles are distributed through a great mass of liquid and become invisible, still the qualities of the sugar are preserved, and on evaporating water we recover the sugar in solid condition, and according to the chemist the qualities are preserved, because the molecules and sugar have remained all the while unchanged."

"Consider, in the second place, a lump of salt. You do not alter its familiar qualities, although you may greatly subdivide it, and the molecules of salt must have all the saline properties which we associate with this substance. Dissolve the salt in water and you simply divide the mass into molecules; convert the salt into vapor, as you readily can, and again you isolate the molecules as before. But through all these changes the salt remains salt; it does not lose its savor, because the individuality of the molecules is preserved. So is it with every substance, it is the molecules in which the qualities inhere, hence the chemist's definition of a molecule: *The smallest particles of a substance in which its qualities in-*

here, or the smallest particles of a substance which can exist by themselves.”

“Considering only the ordinary chemical relations of the two substances, the molecule of sugar differs from the molecule of salt in precisely the same way that a lump of sugar differs from a lump of salt. In a word, what is true of the substance *en masse* is true of its molecules.”

In view, therefore, of these wonderful facts and of the uncertainties which they suggest, and of the possibilities which they reveal, it will be becoming in us to lay comparatively little stress on theories and observe closely facts.

It has been said, and is by many held true, that a symptomatologist, or one who prescribes upon the totality of the symptoms, ignores pathology and diagnosis, to a certain extent, and cannot be a good diagnostician. This charge is unfounded, if we interpret the totality of the symptoms correctly, and as indicated by quotations above. Furthermore, I believe and contend that, other things being equal, an accurate and comprehensive symptomatologist is a better diagnostician than he who gives his attention solely, or chiefly, to pathology and diagnosis, and for the reason that the peculiar symptoms of a drug oftentimes point to a diseased organ that has not been thought of by the physician, nor mentioned by the patient, and serves as an index that often leads to the discovery of an obscure lesion. As an instance, we have before us to-day a patient who has been in the hands of the internes for a considerable time, suffering with rheumatism. The patient has not been benefited.

On examination we find that she is about forty-six years of age; that she is worse at night, being very restless, especially about midnight; that she suffers more before stormy and in damp weather; that gentle motion ameliorates the pain; that she perspires easily and freely; that the pain is located in the legs and back, and is muscular in character; that her trouble dates from taking cold while overheated. On further inquiry we learn that the patient has received, at various times, *Rhus tox.* and *Mercurius*. Sufficient time has elapsed for the remedies, had they been homœopathically indicated, to



have made an impression upon the patient's condition. No improvement has followed, consequently we are justified in presuming that neither was the right remedy. There are other symptoms here that have been overlooked. We find that the patient's circulation is poor; that her feet are extremely cold by day, and extremely hot at night; that she suffers from severe vertex headache, with great heat on vertex; that there is an empty, gone feeling in the abdomen, especially about an hour before the noon meal. These symptoms point to a remedy often called for in strumous conditions, where there has been a tendency to skin eruptions, and where these skin eruptions have been suppressed by local applications. This is the point I want to make in regard to the symptomatologist having an advantage as a diagnostician.

On inquiry we learn that this patient had, as a child, a bad case of the itch, and she remembers distinctly, she says, that she was stripped and rubbed thoroughly over the affected surface of the skin with sulphur ointment, usually made from a combination of sulphur and lard; that, as a result, the eruption disappeared. Here, then, is an instance that teaches both ways. In the first place the symptoms indicating *sulphur* suggested a pathological condition, otherwise utterly obscure, of suppressed itch. and suppressed itch, on the other hand, is a pathological condition that suggests sulphur as a remedy. This case perfectly, as far as it goes, illustrates the necessity, as expressed by Hahnemann and Dunham, of considering the totality of the symptoms, including pathological conditions, history and immediately existing nervous phenomena.

We find, furthermore, that this patient sleeps poorly, wakes often at night; that the application of cold water to the skin is extremely disagreeable, causing shivering and chills; also that her urinary symptoms correspond with the symptoms of *sulphur*; she has at one time scanty and high colored urine, at another time it is very profuse and watery. In short, she presents a perfect picture of sulphur, which will be prescribed.

*NOTE: This patient improved promptly and rapidly as reported each week.*

The next case presenting reports marked improvement from remedies prescribed by the house physician, and I will now undertake to tell you what remedy he prescribed. If I can do so, it is positive evidence as far as it goes in favor of the proposition that Homeopathy is a science, as the remedy is selected from two hundred or more.

On examining the patient, we observe first, a sallow complexion that suggests a certain drug. On further inquiry, we find that the symptoms are aggravated always about four o'clock in the afternoon; that there is pain in the back, in the renal region, and that it is aggravated after a desire to void the urine has manifested itself; and that relief from the pain follows evacuation of the bladder; that the patient's appetite is poor and deceptive; she sits down at the table with a fair appetite, but a mouthful or two satisfies her; a sense of satiety is produced after eating but little; that much gas is generated in the abdomen, producing a full sensation with rumbling. Patient is constipated, the stools being dry.

Here we have an excellent picture of a remedy that acts equally well upon the kidneys, liver and stomach, and I name the remedy the house physician prescribed, and under the action of which this patient has improved so notably, to be *Lycopodium*. The house physician, on reference to his books, says *lycopodium* was the remedy.

The next case is one of rheumatism of several years standing. The patient about that time was exposed much to the weather, and was frequently wet in storms while heated. This patient has also improved noticeably under the action of the medicine administered by the house physician. The characteristic symptoms in this case we find to be that the left leg and arm are the seat of pain, that he is always much worse before a storm, especially a rain storm, and is relieved to a certain extent after the rain has begun to fall; that the pain is more severe while sitting; that he is very stiff on beginning to move, but that gentle motion greatly relieves the pain; that he is very restless at night, especially from twelve to one, being obliged to turn frequently, backward and forward, from side to side, on account of the pain; that after each movement

he is easier for a brief time, then is obliged to turn again; pain is of a bruised or tearing character.

Now, from these symptoms, it is evident that *rhus tox.* is the remedy, and the house physician says that was the one he prescribed.

The next patient is a female about forty-six years of age. It is climacteric period with her; she complains of sleeplessness, wakes often at night; poor circulation, her feet being either extremely cold or extremely hot—cold in the day-time, hot at night, especially on the soles. She complains of an itching eruption upon the thighs, which distresses her very much; she complains also of pruritis vulva, and she says this has been her most distressing symptom. She complains also of vertex headache, with heat on the vertex, sudden hot flashes over the body, very weak, faint spells frequently during the day, extreme hunger, and empty, gone feeling in the abdomen, always hungry an hour before meal time. Family history indicates phthisis; lost one sister with consumption; also one maternal aunt died of the same disease. There is no recollection of any skin disease in childhood or at any other time, excepting the eruption now complained of.

The remedy here is undoubtedly sulphur; she has improved on that remedy markedly during the past five weeks. The house physician says that he gave her, according to my teaching, three powders of sulphur, to be taken on successive nights, to be followed by placebo; that she has been improving at each weekly report since that time, five weeks ago, and that he has not repeated the prescription during that interval.

I believe this to be the correct way of treating, especially chronic cases, and there are physiological and philosophical reasons for the belief. As a rule, the function of medicine is not understood. Too often the physiological functions of the body are supposed to be performed by the drugs prescribed. Diseased action being a wrong working of the governing power of the animal economy, that governing power being the nervous system, evidence of diseased action indicates something wrong with this governing nervous system. The function of medicine is simply to remove the cause of that wrong work-

ing, then nature through the nervous system repairs the tangible results, of whatever nature, of this deranged action. After medicine or the remedial agent has corrected this wrong working, and, so to speak, set nature on her feet, it is not only of no use, but is a positive impediment to nature, if drugs are persistently given after their work has been done. Nature, relieved of the incubus, goes on and does her own work—she is her own scavenger and builder. A perfectly healthy organism is stronger and healthier than the same organism *plus* drugs, in other words, drugs can add nothing to health. Drugs are inimical to the animal economy, and nature expels them as quickly as possible. There are no drugs in the healthy body, consequently it is absurd to say that tonics and other drugs will “build up” a patient. There are no such materials in the physiological body. Even of iron, so much lauded in this building process, there are but thirty grains in the average adult healthy body; all administered in excess of that amount is expelled with the feces. Medicines simply enable nature to do her best, they can add nothing to perfect nature, consequently, when we have evidences that a medicine has done its work of removing a stumbling block from nature’s way, and that nature is now working in a physiological manner, and this evidence will be indications of improvement, of relief from pain, of a general better feeling, etc., it is worse than useless, so long as the patient improves, to administer more medicine. The work of nature is being done. A disregard of these facts leads to a too frequent repetition or changing of medical agents in the course of treatment of chronic diseases, and a consequent jeopardizing of the patient’s recovery.

I will call your attention to one more case illustrating the advantage of characteristic symptoms in aiding the making of a correct diagnosis.

The patient is a gentleman of sixty-five years. He had always, up to the time I first saw him, employed allopathic physicians, and during the present illness had consulted quite a number besides his regular family physician. Among those consulted were two prominent—and so recognized—specialists in physical diagnosis.

I first saw the patient August 12, last. I found him in a serious and even alarming condition. His legs were dropsical throughout their whole length. The bloating extended into the abdomen and thorax, so that he could breathe only with the greatest labor. The slightest movement in attempting to walk produced painful dyspnoea, with a facial expression of the greatest anxiety. The serious period of his trouble dated back four months, during which time up to the present, he became gradually worse. During the ten days preceding my first visit he had not laid down at all. The attempt to assume the recumbent position caused attacks of dyspnoea, which threatened fatal suffocation, and closely resembled violent paroxysms of asthma. His tongue was heavily furred; no appetite, notwithstanding which the orders were—absurdly enough—to force the feeding. In the light of a correct diagnosis, the mistake of forced feeding in this case was almost homicidal, and would have been altogether so, I have no doubt, had it been continued much longer.

His heart was laboring violently, with regurgitant mitral murmur quite distinct. Bowels constipated; face haggard.

The diagnosis, as had been expressed to the patient's friends, and as they told it to me, was "Heart disease complicated with Bright's disease and asthma." Prognosis unfavorable. In fact, they had given him up, which was the only reason the formerly bitterly prejudiced old gentleman would consult a practitioner of the much-ridiculed Homeopathy.

An hour's careful investigation convinced me that the origin of the man's distressing condition was neither in heart nor kidneys, and that there was no asthma in the problem. The much abused stomach, and secondarily the liver, were repaying their hard task-master, and were the first and chief causes of the whole trouble; and I was first led to this way of thinking by the fact that the two remedies vying with each other as to which should be selected as the *similimum* were both essentially remedies for the digestive apparatus. None of the so-called acute heart medicines were at all indicated. Following the hint thus received from symptoma-

tology, I arrived at a correct diagnosis, as above indicated. The remedies were *Arsenicum* and *Nux vomica*.

I learned that the old gentleman had always been a great eater (he had in three months lost fifty pounds in weight), and was utterly regardless of dietetic rule or reason. Before his symptoms had become so alarming he had had occasional very severe attacks, which always followed excess at the table. Then the foolish course of the physicians in forcing the feeding, even when the patient's stomach revolted at the sight of food, capped the climax, and nearly brought the old man's gray hairs down with dyspepsia to the grave.

I was so confident of my diagnosis of both condition and remedy that, contrary to my custom, I confidently predicted recovery. He wanted sleep. "For God's sake, doctor, make me sleep," was his earnest prayer. I explained to him that the doctor couldn't "make" one sleep, unless, indeed, it was "the sleep that knows no waking," and that that kind didn't belong to our school. I showed him that "sleep—balmy sleep—was tired nature's sweet restorer," and that tired nature would always sleep if she were well and had an opportunity, and that the duty of the physician and the function of medicine were to make him well, and then, the other conditions being met, he would sleep. I advised him, as it is well to do in all such cases, that he would probably not be able to sleep at all during, at least, the first night, as he would feel the absence of and reaction from the anodynes he had been taking all those weeks. I explained to him the absurdity of using anodynes in such cases. I told him he might sleep a little the second night, a little more the third night, and so on, until in a week he would probably sleep all night. The result proved the correctness of diagnosis, prognosis and treatment. He did not "sleep a wink" the first night until six o'clock in the morning, when he slept—*lying in bed*—one hour, the first sleep in a recumbent position he had had in ten days. The second night he slept several hours, an hour at a time, getting up for awhile about every hour. The third night he said he would have slept all night if it had not been for the fact that he was obliged to get up every hour to urinate. He said it was mar-

velous the quantity of water he had passed during the night, and he was greatly alarmed lest this was an evidence of the correctness of that part of the expert diagnosis which had doomed the kidneys. I asked him as to the size of his legs. Lo! they were reduced in size once by half! I told him to put this and that together, and he could see that cause of the excessive urination was evidence, not that the kidneys were idle, but that they had steam on and were working up to their full capacity. And so it was. The result of all was at the end of a week *all* distressing symptoms, including dyspnœa, dropsy, palpitation, etc., had disappeared and he was sleeping the sweet sleep of health. He was attending to his duties as a member of the Board of Trade in less than three weeks from the time I first saw him.

I gave his stomach a needed rest during that time. The first week he took absolutely nothing except hot water, with occasionally a "dash" of milk in it—"cambric tea." The second week not much more, nor until the coating was completely removed from his tongue did I allow him solid food. He has swallowed no meat at all. I allowed him to masticate beefsteak or lamb-chop and get the juice. Any slight indiscretion of diet, even yet, will disturb the heart and cause a slight swelling of the feet.

*Arsenicum* or *Nux vomica*, as either seemed to be indicated, were the only medicines he received.

A LECTURE INTRODUCTORY TO THE COURSE ON  
PHYSIOLOGY IN THE HAHNEMANN MEDICAL  
COLLEGE AND HOSPITAL OF CHICAGO.

DELIVERED SEPTEMBER 19, 1888, BY PROF. JOS. P. COBB, M. D.

"Human physiology is the science which treats of the life of man—of the way in which he lives and moves and has his being."

It teaches how man is begotten and born, how he develops, declines and dies. It is the study of the phenomena of life. It makes us acquainted with their causes, their manifestations, their mechanism and their results.

We must study the living body as a machine, recognizing the value of each and every part, as the engineer familiarizes himself with each and every part of his engine.

In the pursuit of this study we are to-day assisted by the arts and sciences, and there is no limit to the accuracy with which our work can be performed, except the limit imposed by the individual capability.

The general functions of life common to all animals can be studied by experimental observations on the lower animals. The absorption of new material and the discharge of waste products, the direct relation between the amount of nutrient appropriated and the manifestations of vitality produced, are features common to all animated existence. The consumption of oxygen and the discharge of carbonic acid gas; the necessity for moisture, and certain limits of temperature are phenomena and conditions indispensable not only to all animal life, but to all vegetable life as well.

The physiology of the human body includes all the general and fundamental facts common to man and the lower animals, as well as the special differences peculiar to man alone. These differences do not, as a rule, affect the character of the vital changes or the methods of their production, but rather the quality or quantity of the same.

Thus animal heat is without doubt produced by the same processes in all species of animals, but the amount produced and the normal variations in health differ more or less for each species and individual. And, with the exception of the nervous system, nearly all the observations requiring to be made upon man relate to matters of detail.

Our knowledge of physiology has been built up by three methods of study, viz.: Observation of the habits and functions of man and the lower animals, experimental investigation, and analogical reasoning or deduction.

We shall find that the latter method has been the means of obtaining the first information of many very important physiological truths; truths which are now so well demonstrated that we accept them as almost self-evident facts, and yet which, when first announced, were often the cause of discussion, ridicule and even punishment for their champions. Here, as in all sciences, direct observation is the only means by which actual knowledge can be attained. Experience has demonstrated that, while analogical deduction and inference often lead the way and open new fields for study, these deductions and inferences must not be accepted as truths until tested by the clear light of experimental investigation. Even the anatomical structure of an organ can never posi-



tively indicate its physiological functions until examination has demonstrated the function to be associated with the structure or organ, yet the repeated demonstration of such inferences teaches physiologists to make deductions which are rendered more than probable by the assurance of former experience and verification. Thus Cuvier, who for all time will stand as one of the world's greatest physiological anatomists, had such confidence in his powers of deduction, based upon his life-long study of comparative anatomy, that he claimed that from a single bone alone he could reason out, picture and mold the animal to which the bone belonged, tell its habitat, the age in which it lived and its habits. And today in all large historical animal museums are specimens, partly the handiwork of man, where only parts of the animal have been recovered, and the remnant, supplied by deductive reasoning, put into material existence by skilled hands.

Let us remember, however, that this power of deduction is the result of long and patient experimental investigation, both in the aggregate and by the special observer, who first puts himself abreast of the times.

The body is a composite structure, made up of many parts, with varied characters and properties. The life of the individual depends upon the combined harmonious activity of all the constituent parts. To fully understand this wonderful activity we call life, and its special form in the human body, it becomes necessary to study each and every part; to recognize its structure and the adaptability of that structure for its special function; to observe the relation of one part to another and to all others; to recognize their mutual bearings.

If we examine individual parts of the body we find that each has its individual structure, and that that structure is adapted to the work it is to do and to no other. We find that the physiological property of muscular fibres is contractility, and that there are two kinds of these fibres, the striped and the unstriped, each of which contracts on the application of a proper stimulus, but with different degrees of rapidity.

The function of a muscular fibre is to contract; not so, however, with a nerve fibre; it has no power of contraction; and if a bundle of nerve fibres were made into proper shape to simulate a muscle, placed in proper position to perform the function of the same, and supplied with the stimulus proper for the muscle, it would not, it could not, execute the function of the muscle.

From this fact we deduce the fact that not only has each fibre its special structure, but that this structure is adapted to its office or duty and to that alone. It may be educated to

a wonderful degree of perfection, but its appointed work will change only in degree. This rule is wide-spread, and covers every organ, fibre and anatomical element in the body.

Let us follow it out a little further; take, for example, the heart; it is composed mainly of muscular fibres, the property of each one of which is this same simple power of contraction, yet the action of the organ as a whole is no such simple movement. True, it has a contraction, but a contraction by no means simple or simultaneous. It has a regular cycle of contraction, a rhythm of action and even a change in shape and position. All of this, however, is the result of the inherent power in the simple elementary fibre. But to accomplish this varied and complex duty requires a certain definite arrangement, a united action and a proper sequence of stimulation. No other muscle in the body can supply the place of the heart muscle, for the structure of no other is adapted to its work. To thoroughly understand any organ, its component parts must be studied, the adaptability of the arrangement of the same for it work, and, not the least important, it should be, when possible, observed while at work.

The study of physiology divides itself naturally into four sections, the first of which is Physiological Chemistry. In this section we shall learn the chemical ingredients of the body; the sources from which they are derived; their composition; their quality and distribution, and the uses they subserve in the body. The second treats of Nutrition. It comprises the processes of the digestive apparatus, including the functions of the glandular organs; respiration and the production of animal heat; the blood, the secretions and excretions. In fact, all the processes which have for their object the vegetative growth and repair of the body.

The third comprises the functions of the nervous system, which, though mutually dependent with those of nutrition, are of a different character, and investigated by different means.

The last section includes the phenomena of Reproduction and Development, those functions having for their object "the continuation of the species."

Before we begin our study of the subject proper, I think you will find it interesting to look back with me over the growth of the science of physiology; to learn something of the errors of our predecessors; the time of, and the conditions aiding some of the noted discoveries in this field.

[To be continued.]

## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

THE OCTOBER MEETING.

The regular monthly session of the Clinical Society was held in Parlor 44 of the Grand Pacific Hotel, at 8:30 P. M., Saturday, October 27, 1888. One hundred members and visitors were present, Dr. George A. Hall, President, in the chair. After some informal business the Society heard

### *THE REPORT OF THE BUREAU OF THE DISEASES OF THE EYE AND THE EAR.*

DR. C. H. VILAS, CHAIRMAN.

This report consisted of the following practical papers, which attracted the earnest attention of the audience.

I. INJURIES OF THE EYE.—By C. H. VILAS, M. D.—All are exposed to injuries of the eye, and in many forms of accident relief must be immediate to save the eye in its integrity. Too much previous study, then, can hardly be given to this subject, that each may be ready to render aid when called upon.

The eye is placed in such a position as to avoid many accidents. The overhanging brow shields it, and it rests in the orbit on tissues which are soft and yielding. But I believe that which best protects it is the inherent sense of approaching danger, this sense so quickened that one eye warns the other, and causes the head to turn or bow instantaneously, the lids to close, and the globe to roll up and back. So speedy is this last movement, that I once knew of an eye which had been so quickly pierced by a feathered dart shot from an air-gun that it showed no injury of the cornea, but a mangled rent in the sclera about the entrance of the optic nerve. To accomplish this the eye must have perceived its danger in a small fraction of a second, rolled upward, and

receiving the dart at that precise moment remained transfixed, as the dart was removed from the wound by traction, and shot into it at a range of about six feet without any warning.

It is also a well known fact that those who have lost an eye, not infrequently receive an injury to the remaining eye that might have been avoided by a person possessed of both eyes. This can best be accounted for by the supposition of one eye warning the other.

It is not a difficult proceeding to remove a bit of coal or other foreign substance from the eye, provided the patient is not nervous, unless the particle is imbedded in some one of the tissues. Nearly all particles might be removed by the patient, if he would remember to draw the upper lid away from the globe and down over the under lid, with a few shaking motions. This manœuvre frees the foreign body from the contact, and the tears from the lachrymal gland, suddenly acting on the stimulus given its branch of the fifth nerve, washes the body down into the inner canthus, where it may be found. But so few are able to accomplish this little manœuvre that turning back of the upper lid is generally demanded.

I purpose to-night, before offering more serious cases, to detail a few lesser ones illustrative of the delicate ways for removing spiculæ that have secured lodgment in some portion of the globe. I shall limit myself to the consideration of twenty-five cases.

Previous, however, I wish to say that such methods as the magnet to remove corneal foreign bodies, the fastening on to them of threads, etc., etc., should usually give way to superior manual dexterity in the handling of instruments. Rare occasions may demand the magnet; it has not happened to me to see cases which required its use at my hands. I have seen others use it, who, judging from the results attained, in my opinion, might have better dispensed with it. To the inexperienced, however, it will continue to be of more or less value for corneal spiculæ; to the experienced its use will be usually limited to foreign bodies in the deeper structures.

1. Mr. W., a machinist, fearing to wear protective mica

glasses, as his companions would jeer at him, worked at an emery wheel revolving with great rapidity. One day, very suddenly, his eyes became filled with emery grains and the debris resulting from his work. He was aided in their removal by a fellow employee, afterward by two or three physicians, finally coming to me.

I found the cornea badly cut by small bits of emery, and under cocaine instilled in the eye, *pièce by pièce* removed the particles with a spud.

2. Mr. W. hunts much, using a breech loading gun. One day, in his anxiety to fire with unusual rapidity, in some manner the cartridge failed to completely enter the barrel, and an explosion without the barrel took place. Grains of powder were forced into the anterior chamber of the right eye, and the cornea was fairly "peppered" with them. The agony was intense, and he declared that something must be done at once.

Under cocaine, with a fine needle, all the grains were removed except those in the anterior chamber. These latter were allowed to remain as consent to their removal was not had; but he desired me to watch the eye, that I might detect at once any unfavorable manifestation. It is true that these incarcerated grains might set up a dangerous inflammation, and if the patient goes beyond my reach serious harm may result.

3. Mr. C. dresses mill-stones during the time the mill does not run. During one of these dressings a piece of the stone flew into the eye, and imbedded itself in the inferior nasal quadrant. A fellow workman was unable to get it out with his tools, though he endeavored so to do, and a resort to the spud under cocaine was necessary to relieve him.

In these cases we have types of the ordinary lodgment of foreign bodies. I could easily multiply cases, but only to add to the number, as the plan of removal would be the same.

A more serious class of cases, however, may claim our attention, and I select and relate a few to illustrate the varying mishaps and their treatment.

4. Mrs. J. was sitting on the porch one evening with a party of friends, watching the explosion of fire-works.

Without warning a piece exploded so near as to strike her eye with a portion of the hot contents. She fainted with the pain, and her husband and friends ran to secure an oculist, and found me. On arrival I found the blepharospasm so great that it was almost impossible to open the lids, but a small fissure was secured and castor-oil poured in between the lids and cornea. An anæsthetic would have enabled me to at once do all I wished, but as the lady was not only somewhat hysterical, but in a delicate condition, consent could not be had to its use. By the time the lids were easily gotten open, she had so nearly exhausted herself that she remained passive, and the few grains of hot powder were removed, and the cornea treated with a solution of atropine and a lightly pressing bandage. A few days sufficed to restore her eye to a normal condition.

5. Mr. M. came from an interior city of this State, stating that a few days before he was riding through the woods on horseback, when a small bough being in the way he pushed it aside with his hand. Letting go of it without much thought, it flew back and a twig struck his eye with much force. He suffered agony, and finally came to me to see what could be done.

The condition of the eye was as follows: The cornea was in appearance cracked like a watch crystal, and in a violent state of inflammation. The iris likewise was inflamed, and the lens opaque. All parts in view seemed mixed in an indefinable mass, and yet there was no solution of continuity apparent. I searched carefully to see if any foreign substance had become imbedded, and finding none, placed the old gentlemen in one of the beds in my department at the Hahnemann Hospital, and had warm fomentations applied, a drop of a two-grain solution of atropia sulphate instilled about every four hours, and *Aconite* given internally.

Without being seen one can hardly form an idea as to how thoroughly his nervous system was affected. The patient shook as though in a constant chill, and stood in continuous need of that support which the remedy named supplies in such cases. After a few days he was sent home, and has called on me frequently to show his eye, healed perfectly, but painful at

times. His advanced age rendered sympathetic trouble little to be apprehended, and unless necessary he ought not to be subjected to the shock of removal of the injured member.

6. Mr. O. came from an adjoining State to see if I could restore a lost section of iris happening with a lacerated wound, which he said was brought about by an unruly cow hooking him suddenly. In addition to the injury to the cornea, there was a complete coloboma of the iris, so perfect that but for his explicit denial I should not have believed but that an iridectomy had been done by the hand of man. This coloboma was about one-third of the iris, and no skillful operator could have excelled the accident in deftness in removing the section of iris.

Inasmuch as the cornea was not injured so as to affect sight and the accident had occurred so long previously that all inflammatory symptoms had subsided, there was nothing to do but to dismiss the patient.

7. I was hurriedly called out one day by a gentleman who had his carriage at the door, and as we hastened away he told me that his wife had gone into a dark closet, stooped over to pick up something, suddenly screamed out about her eye, vomited, fainted, and when he left was still moaning that her eye was paining her intolerably. On arrival I found a lady on the sofa, learned that she had steadily refused to open her eyes, and constantly complained of the pain.

On examination I found a large swelling at the inner canthus of the right eye, and succeeded in getting the eye open, to find the globe uninjured, but the inner portion of the orbit excessively tender and painful and the tissues rapidly swelling.

What was the cause of the injury? Viewing the spot I found she had opened the door of a rather deep closet, plunged in from the bright room, and the darkness of the closet hiding its contents, when she impulsively stooped she failed to notice a long iron-handled skillet with its handle projecting toward her, and its basin lying in the angle of the walls and firmly held there. As she bent over the end of the pointed handle was pitched just right to receive her weight as she struck it with the portion mentioned of her head.

Rest and cold applications were all that were necessary to cure her injury. The cause of the wound is unique.

8. Mr. L., from Iowa, suffered intensely when he came to me from a wound caused by the peck of an owl. He said he undertook to tease the bird one way and another, poking his finger at him, and similar ways, when unconsciously putting his head too closely, the owl quickly struck him with his bill.

Careful examination showed the cornea had been penetrated and the lens injured, so that it had become cataractous. The external wound had healed and not involved the iris, and an operation to remove the cataract would have doubtless yielded good results. But one good eye remaining, he believed his occupation as a farmer not imperiled, and as the companion eye was not endangered, he decided to do nothing with the injured eye.

9. Mr. B., of Chicago, suddenly opened a carboy of strong ammonia, and in consequence received a bit in his eye as it splashed from the nozzle. His place of business was opposite my office, and he hurried across the street in great alarm, believing that great damage had been done to him.

After washing out the eye carefully with water at the hydrant, some castor oil was placed between the lids, and as no serious lesion was observable, he was dismissed with no further treatment. But serious damage occasionally happens from a similar cause, and the case should be treated in the manner usual for burns from strong acids.

10. Mr. D., from Iowa, put too much confidence in his ability to defend himself from a setting hen. She suddenly pecked him as he stooped over to pull her off her nest, and thereby came off victorious.

By the time he reached the city it was difficult to see into the anterior chamber of his right eye, the cornea was in such an inflamed state. After applying warm lotions until the concomitant swelling was down, it was found that the bill of the hen had not penetrated the anterior lens capsule, and the iris had also escaped with but a slight abrasion. A few drops



daily of a two-grain solution of atropine, and a bandage, soon rendered him convalescent, and he went home. It is quite likely that he will bear a marked scar on his globe.

He left assuring me that no hen would again get near enough to injure him.

11. Master M., of Chicago, was chasing a fellow lad on the sidewalk when he suddenly felt something fly up and strike him in the eye. He was blinded for a moment, but quickly saw that it was a telegraph wire on which he had stepped. Much alarmed, he ran into the house, and his father hurried him to my office.

A small corneal abrasion was the only result, although the escape was most fortunate, as so treacherous an instrument might easily have destroyed the sight. Slight bandaging and cool water quickly cured the injury.

I have seen other injuries from the same cause, our streets and vacant lots often being used as a dumping ground for such and similar refuse

12. Mr. Y., of Chicago, came home one night, and in a hasty pulling off of his shirt, the cuff button swung around and struck him sharply in the eye. He at once put cold water on, and kept it on a large share of the night, and came to see me the next morning.

There was marked ciliary injection, diffused redness of the conjunctiva and great sensitiveness to the light. Careful examination showed all the delicate parts in their normal positions, and under atropine the eye cleared up, and in about two weeks was normal to view, although he assured me it had a peculiarly sensitive feeling for many months.

13. Mr. O., a carpenter, came with a history of shingling on a roof, when, as a result of a slanting blow, a nail flew up and struck him on the eye. This had occurred some weeks previously. He had not at first sought advice, but finally went to some one, but eventually fell in with an old patient of mine who brought him to me.

Oblique inspection showed a dislocated lens lying half way into the anterior chamber, in which position it had lain doubtless for weeks. Its presence had excited inflammation

of the iris, and it was now held firmly by the synechiæ which had formed. The aqueous humor was turbid, and the iris highly inflamed. The globe was hard, tumified, and evidences accumulating of purulent choroiditis.

I foresaw enucleation as the only result, but endeavored for several days to reduce the inflammation in the hope that I might get the lens out by an operation, not now a likely result, as it was so firmly held, and the eye so inflamed, but a proper procedure in the beginning. But this attempt was unsuccessful, and enucleation was necessary and performed.

14. Mr. L., being of a light turn of mind, was disposed to frolic with his wife before retiring. Playfully hitting out with his hand, he stood in too close proximity to his better half, and lightly touched her with the end of a finger nail. This contact removed a bit of the corneal epithelium, and instantly terminated the sport. The agony of his wife was unendurable, and conjugal caresses being of no avail, the next day they ruefully sought extraneous aid.

So slight an injury is often exceedingly painful. I have seen many such. All quickly yield to an appropriate bandage and the instillation of a few drops of atropine, or may be temporarily appeased by a cocaine solution. Castor oil may be advantageously placed beneath the lids.

15. Master J. was playing "shinny" with other boys, when a badly directed shot drove the little block of wood against his right eye. He was taken to the family physician, who saw nothing but a little bruise and redness, and he was treated by him for a number of days. Finally his mother brought him to me.

The external wound not being sufficient for his symptoms, I examined him with the ophthalmoscope, which revealed all quickly. In the outer half was a marked rupture of the choroid for a distance of about half an inch in a vertical direction.

As the patient only came for diagnosis, being on the way South, I gave no treatment, and though I understand he went under the care of another oculist, I have never heard from the case since.

16. Master T. went to play with his cousin, who had an air-gun which shot feathered darts. In the process of the game, accidentally the gun went off in the hands of his cousin, and the dart struck the patient in the eye with much force.

About the third day the patient was brought to me by his father. The eye was fearfully lacerated, the dart having penetrated the cornea, iris, lens, and, as I was informed by his father, became so imbedded in the soft tissues posteriorly as to require some considerable force on the part of the local surgeon to draw it out. I could only advise enucleation of the injured member, which advice was followed, and the eye removed.

17. Miss M., a young girl, was playing with her dolls; one of them would not sit up to suit her, and so she put a tack in its dress to hold it to the floor in the desired position. When play was over she took a tack-puller, and placing it under the head of the tack, pulled upward with both arms extended. In some manner the tack, giving way, plunged into her right eye.

Medical aid was summoned and everything done that was possible. I was in Europe at the time, and on my return I assisted in the endeavor to assuage the evidently impending irritation of its companion eye. This finally set in, and no longer daring to tempt the lurking sympathetic ophthalmitis, I enucleated the injured eye. All sympathetic symptoms ceased at once.

Dissection of the removed eye disclosed a plastic choroiditis, induced by the tack having penetrated the ciliary region, that spot so liable to the propagation of this destructive inflammation.

18. Mr. L., of Dakota, was tending a stationary engine used in running a threshing machine. While noting the pressure of steam, the water-gauge blew out and filled his eyes with finely powdered glass. After submitting to such local aid as was at hand, he came to the city for further treatment.

The left cornea was almost filled with powdered glass,

and the conjunctiva much cut. The particles were carefully picked out, and the space between the lids and globe filled with castor oil, and atropine and a bandage used. The right cornea was badly cut at the upper portion, in addition to injuries similar to that of the left, and the iris prolapsed. Both lenses were uninjured. The prolapsed iris was snipped off, forming a good iridectomy, the remaining part of the iris returned to the aqueous chamber, and a similar treatment to that of the companion eye applied.

After some weeks he recovered, with excellent sight in both eyes.

19. Mr. R., aged about sixteen years, went to the circus, and imbibed a taste for horse training, which led him to lead from the stable one of his father's horses, attach a long rope to the halter, and run the horse around an imaginary ring. The horse rebelled, the lad cut at him with the whip, when the horse, having a long leash, turned and kicked backward. By a singular freak the cork of the shoe struck so as vertically to cut the lids of the right eye, which must have closed foreseeing the shock, and to make a long, mutilated rent of the flesh near the brow. The cut was sewed up, and when I saw it the cicatrix had drawn the lids so that the four corners of the two cuts were drawn squarely back, exactly as one would dissect back the soft parts from a crucial incision. The globe was unharmed.

A plastic operation was advised, but the parent decided to take the boy home unaided by any operation.

20. Mr. E. was employed by a large firm to put down carpets. Having temporarily fastened a portion of a carpet while permanently securing another, he returned and drew out the tacks first driven. In so doing he pulled with such violence that in some manner unknown to him he drove a tack into his eye, where it remained until forcibly withdrawn. Unfortunately it pierced the ciliary region, and but a few days elapsed before the other eye showed sympathetic irritation.

The eye so rapidly grew worse that it was necessary to remove the injured eye to save the other, and it was enucleated.

21. Mr. L. worked as a machinist, and tended a lathe

which revolved toward him. In so doing it chipped off a piece of iron, which passed directly into his eye. He came to see me at once, and desired that I should save the eye if possible. The piece had gone directly through the ciliary region, leaving a large track where it had cut through and imbedded itself in the deep parts of the globe. To demonstrate to him the necessity for the removal of the eye more than for any other reason, I consented to his earnest demands that I allow the eye to remain to see what it would do.

At the end of forty-eight hours, after suffering untold agony, he begged me to remove it, and I did so. Dissection revealed a marked case of purulent choroiditis, and demonstrated the actual necessity for speedy enucleation.

22. Mr. G., an old gentleman, was splitting wood one evening, when a piece flew up and struck his eye. I was called, and arrived about four hours after the accident. The patient was trembling like one with *delirium tremens*, vomiting at intervals, and constantly crying out with the suffering and the apprehension that the eye must be removed at once.

Careful examination revealed that the blow had broken the lens capsule, the other structures escaping but for the shock. Of course this would render the lens cataractous, and consequently the sight would be lost. He was entirely satisfied, provided the eye could be allowed to remain. Hot water fomentations to the eye, with a few drops of a four-grain solution of atropine, relieved the pain, and rest and quiet were ensured by appropriate remedies. No complication ensued, and he has his eye to-day.

23. Master B., a lad employed as a messenger in a wholesale house, partook of the spirit of our national game and aspired to base-ball. A hasty practicing while on his way home resulted in his being hit in the eye with a ball.

Although a careful examination showed no lesion whatever, it is too well known that such blows frequently produce a traumatic cataract, for any but a cautious prognosis to be given. Unfortunately this was one of those cases, and his lens slowly and painlessly developed a cataract, which closed the pupil and deprived him of his sight in that eye. At this

time his father has not decided to have anything done to relieve him.

24. Miss B., when about twelve years of age, pulled down on her head, as she expressed it, a window, which broke the glass, and slightly cut one eye. She had a good oculist, who told her that the injury was in the ciliary region and that it seriously endangered the other eye. Nothing was done, however, and the eye healed and she forgot about it. About ten years afterward the other eye sympathized: she was urged to have the originally injured one removed, but, although she was willing, her father would not consent, and that one was quickly lost too. Some two years after she came to see me, but it is to be regretted that there was nothing known in our art to aid her.

So many similar cases are scattered about the country that it is sad to think that they should have been allowed to attain hopeless blindness. Dreadful as the alternative of enucleation is, one eye is infinitely better than none.

25. Mr. L., a machinist, felt something fly into his eye. He knew it was a piece of steel about a millimetre wide, two and one-half millimetres long and a quarter of a millimetre thick. It did not come out, and the doctor could not see it in his eye. He was sure it must be there, however, as it was missing from his piece of work and he felt it go there. It ran on a week or so, when he decided to go to Chicago.

A careful examination of the eye showed the piece to be imbedded in the cornea, a small angle of it projecting backward into the anterior chamber. The double-needle operation seemed indicated. This consists of passing a needle through the cornea behind the foreign body to steady it, and with a second needle to lift out the foreign body, the first needle also assisting in the effort of traction. But the piece had been there so long, and so much suppurative was threatening, that I was fearful of prolapsing the iris. I therefore conceived it better to aid the suppurative process a bit, and await my opportunity to draw the body with the forceps.

I did so, and in about three days was enabled to with-

draw the piece easily, and leave a sound eye, as the cornea quickly returned to its natural condition.

Had I not decided to limit myself to the number of cases stated at the beginning, I should feel inclined to go on citing curious accidents which have fallen under my notice and care. I could continue the narration of injuries, of which these are but disjointed types, but enough cases have been given to show the treatment and the varied nature of the accidents which are daily occurring.

I note others, however, among which are a boy injured by a horse running away and pitching him from the wagon into a glass-heap; many eyes badly injured from gunpowder explosions; some cases from strong acids spattered into the eye; one from falling on to a harrow; one who stepped on a rake, causing the teeth to fly up and strike the eye; another from hot lead spattered into the eye, with all its disastrous results; numerous punctures from scissors, causing loss of sight in both eyes; and many others, wearisome to enumerate.

I trust I have said enough to show that apparently trifling wounds are serious in the eyes; that too much care cannot be given to any wound of that valuable member; and that all should be fully prepared to render intelligent aid in any emergency.

**SURGICAL EYE CASES.**—By G. A. HALL, M. D.—Dr. H. V. Halbert read the following paper for its author:

Owing to the complications of the eye in the following surgical cases, I take the liberty of presenting them, together with some clinical points relative to general surgical operations adjacent to the eye. As the nerve supply of the facial district, and the scalp as well, comes from the same ganglion which supplies the eye and the nasal fossæ, we readily recognize how injuries of the face, forehead and scalp may indirectly affect the organ of vision. For this reason it is doubtless true that morbid growths or other diseased conditions of these regions may be the exciting causes of local affections of the eye.

The subjoined cases may to a certain extent illustrate some of these points.

*Case 1.*—Mr. C—, aged forty, entered the Chicago Surgical Institute July 24, desiring treatment for a cutaneous trouble underneath the left eye. It occupied a space about two inches long by one and one-quarter in width, resting upon the upper and inner border of the malar bone, and extending along under the eye for about half the length of the lid and upward to about a quarter of an inch from the free border of the lower lid.

The history he gave as follows: Seven years previous he first noticed a little dry spot upon the malar prominence, which was about the size of a pea. This gradually enlarged, and resembled the scar from a burn. After a time it began to itch incessantly. The irritation extended to the eye, and copious lachrymation would occur whenever exposed to the cold. As his business required him to be out of doors at all seasons, the whole difficulty was greatly aggravated during the fall and winter months. When the lachrymation became excessive, he formed the habit of rubbing away the secretions with his gloved finger, which greatly increased the irritation.

Almost three years ago this surface began to ulcerate and take on epithelial formation. The eye became unusually red, and the vision was impaired. Frequent darting pains were felt in the eye-ball, and disagreeable stinging pains attended the ulcerated surface.

The oculist whom he consulted claimed that the vision of the eye could not well be attended to until the ulceration of the face was healed. Various applications had been given for this purpose with little or no beneficial results. The erosion continued to spread, and all the unfavorable features of the case were augmented.

Believing that the case was not amenable to local applications or remedies, the entire ulcerated mass was removed, the integument was dissected as far down as the inferior maxillary, and then stitched to the remaining portion of the inferior lid. By so doing the raw surface was covered completely, and the parts united by first intention. Subsequent action of the muscles of the face caused the outer angle of the eye to droop to a slight extent. Otherwise the result is more than could be expected of such operations.



Since the parts were perfectly healed no pain or inconvenience of any kind has been felt. The vision has improved about fifty per cent, and the slight deformity of the lid we have promised to repair at his earliest convenience.

The object in stating this case is to show the pernicious effect of such formations, adjacent to the eye, both upon the vision and the mucous surfaces of the eye. The continuance of any such condition must lead to serious impairment of the eye and the ultimate epithelial involvement of the more important structures of the socket. The removal of such formations should be early in their history, long before they have encroached upon the organ of vision. We advocate the use of the knife in all such cases in preference to the plaster, escharotics, or injections with a view of causing sloughing.

The reasons for this procedure are: (1st) Because it is a safer method. (2d) Because it is less painful. (3) Because it saves time. (4) Because it prevents serious deformity resulting from extensive cicatrization.

*Case 2.*—Mr. L., aged forty-five, about a year ago, while in a state of delirium, the result of a severe attack of facial erysipelas, conceived the idea of putting an end to his life. According to his report he considered the matter as thoroughly as a delirious subject could, and decided to perform the rash act by means of a pistol, which he knew was in an adjoining room. Taking the precaution to carefully robe himself, as it occurred to him that he might catch cold in going from one room to another, he gained possession of the weapon, returned to his bed, disrobed, and with his right hand aimed the pistol obliquely toward the forehead, and discharged the contents of one chamber. The ball passed through the integument, about one and one-half inches above the superciliary ridge of the left eye. Passing obliquely to the outer angle of the superciliary ridge, it made its exit. The outer table of the frontal bone was apparently all that was involved. A physician was summoned, who dressed the wound, claiming that he had removed all of the ball. The erysipelatous trouble subsided, but the eye was the source of much irritation. He came to this city, and the left eye was enucleated by Prof.

Vilas. The recovery was rapid and perfect, but some time after he had returned to his business he found that the remaining eye gave him much trouble, and there was a constant deep-seated pain over the left socket. He returned to the city, and was referred to me by Prof. Vilas. He was placed in the Surgical Institute, and under the influence of chloroform we made an incision from the middle of the frontal bone down the median line to the junction of the nasal and frontal. From this point a curved incision was continued over the arch of the left superciliary ridge to the outer angle. This triangular flap was dissected back, and a punctured, comminuted fracture of the outer table of the frontal bone was exposed.

As we had been informed that the ball had been extracted at the time of the injury, we were curious to understand why pus was constantly oozing from the puncture in the outer table. By means of the trephine and chisel the cause was soon learned. When the ball struck the frontal bone it evidently split into two portions. The larger fragment, passing on underneath the occipito-frontalis muscle, was removed by the attending physician. The small fragment, about twenty grains in weight, passed through the outer wall of the frontal bone, down through the cancellated structure, and striking the upper floor of the orbit had produced a slight puncture and fracture, where it was found resting upon the upper surface of the wall of the socket. Through this small opening pus was passing down into the socket and out at the inner angle of the eyelid. This fragment being removed, a rapid repair took place.

The object in reporting this case is to show the importance of trephining for fragments of bullets when they have penetrated the outer table. It was, possibly, the irritation of this small fragment which made it necessary to remove the eye. Had it been removed at the time of the injury the eye might have been saved.

III. LOCAL TREATMENT IN SUPPURATIVE INFLAMMATION OF THE MIDDLE EAR.—By JOSEPH WATRY, M. D.—In looking over the statistics of some of the deaf institutions I found that

deafness in about three-fourths of the inmates is due to purulent inflammation of the middle ear. During the three years that I have been connected with the Hahnemann Hospital from 35 to 40 per cent of the total number of ear patients had discharges from their ears. This shows that suppurative inflammation is one of the most frequent ear diseases, and therefore I judged it not out of place to submit a short outline of local treatment to the discussion here to-night.

Mothers often make the remark that their physician advised them not to have the discharge stopped from the child's ears for fear that it may bring about some other and more serious trouble; or that in time the child would "out-grow" the disease. Such remarks sound very agreeable to the tender-hearted and ignorant mothers, but they are only too often the cause of partial or complete deafness, and even of death. No time should be wasted; the cases should be treated as soon as the discharge makes its appearance, and the treatment should not be abandoned until the discharge has ceased. These cases, as regards the termination of the disease, may be grouped into four classes.

In the first class the discharge from and the inflammation of the mucous membrane gradually subsides, the perforation cicatrizes, and complete recovery of the function of the organ of hearing takes place.

The second class terminates almost the same as the first, but permanent damage to the organ of hearing is left behind, which may be the result from prolonged granulations or polypi in the tympanic cavity, or thickening and rigidity of the mucous membrane and ligaments may have taken place.

In the third group the discharge also ceases, but the drum-head does not repair, and the hearing power is very much impaired from the same causes as in the second group.

In the fourth class the discharge does not wholly cease, and yet the hearing may remain tolerably good for many years. If the cases are seen early, that is, before any serious pathological changes have taken place, and if the proper treatment is given, fully 75 per cent terminate as in the first group. 1. The first and most essential point in the treatment of these cases is to keep the cavity clean from all morbid secretions. I found that if the perforation in the drum-head is of considerable size, and not located too high, that warm water properly applied with a two or four ounce syringe, followed by wiping and drying the canal and tympanic cavity with the cotton and probe, gives the best satisfaction. Some are in the habit of relying wholly upon the probe and cotton to cleanse the ear. I do not look upon such a procedure as

advisable, because no matter how gently the cotton is applied it is bound to cause irritation, and in some cases even severe pain, as the parts are extremely sensitive. In other cases the discharge is so tenacious and stringy that it is impossible to cleanse the parts by this method alone. The Eustachian tube must not be forgotten, for it plays a very important part in keeping up the inflammation if ignored. The function of the tube is to ventilate and free the cavity from the secretions. In suppuration of the ear a certain amount of the secretion finds its exit through the tube. If the secretion is thick and sticky the tube becomes plugged up, and the retention of the discharge excites inflammation. It is therefore of the greatest importance that the Eustachian tube should be cleansed as often as the tympanic cavity. It is best done by driving out the secretion with the air douche and then delicately removing it under strong illumination. Quite often cases are seen in which the perforation in the tympanic membrane is very small, or located too high to allow all of the pus to escape. In such cases it is best to incise the membrane in a more favorable location, or to enlarge the already existing opening. When there are two perforations it is often very good practice to introduce a soft rubber canula in the upper and to inject some solution which washes out the secretion through the lower opening. This method has been of the greatest benefit to me in some of the most obstinate cases. 2. The second point to observe in treating suppurating ears is to reduce the inflammation and to modify the morbid process. The cotton and probe should not be used too long and too frequently, nor should the syringe be used too forcibly, as such treatment would rather increase the inflammation. If the patient is an adult, and exposed to the changes of the atmosphere, cotton should be worn in the ear.

In the acute cases with great pain, caused by the intense inflammation, the continuous use of hot water is of great value. There are, however, certain cases in which the prolonged use of the hot water is contra-indicated. When there is but a small perforation, and the drum-head presents a pale, milky, sodden appearance, indicating that it has been undergoing softening, the continual stream of hot water should not be used, for this would tend to soften the membrane still more and destroy it completely. Great care should also be taken while inflating such an ear. Too great pressure upon the air-bag may cause the drum-head to tear in several directions. Dry heat should be used in these cases to lessen the pain. The tympanic cavity should be cleansed by filling the external auditory canal with water, then by placing a pledget of cotton

in the meatus, and inflate the ear by Politzer's method. In doing this some of the water enters the cavity through the perforation, and by repeating this procedure several times it is, in most cases, sufficient for perfect cleansing. If the secretion is, however, stringy, so as to plug up the perforation, it is best to replace the water by a solution of bicarbonate of soda or boracic acid, and to use Siegle's otoscope, with a rubber bulb attached to it, to force some of the solution into the cavity and to draw away the secretion with it.

If the inflammation and discharge is moderate, proper cleansing, in connection with a good, selected internal remedy, is all that is necessary for a favorable termination. I very seldom use local medicine in similar cases. When, however, more or less changes have taken place in the tympanum, such as swelling and thickening of the mucous membrane, with a very profuse, thick and yellow discharge, giving off a disagreeable odor, I most always use local applications.

I have heard of doctors, and even of specialists, being opposed to the use of local applications, but I have never seen one who did not resort to them if called upon to treat obstinate cases. The local remedies which I most frequently use are boracic acid powder, nitrate of silver, sulphate of zinc, sublimate of mercury, peroxide of hydrogen, etc. Some claim that this is not homœopathic, while others assert that they have seen injurious results from their use. According to our materia medica, borax is indicated in accumulations of mucus on the mucous membrane of the throat when it is tough and difficult of detachment. In lung trouble, when the expectoration has a sort of musty, moldy odor, while the leucorrhœa of borax is clear, copious and albuminous, with a sense of great heat, there is a similar mucous membrane in the tympanum, which gives off the same discharges when diseased. Now, why should boracic acid powder not be used locally in these cases? I am of the opinion that the action of this powder is very much the same as that of borax. The characteristic discharge of *Mercurius* is also found in suppurating ears, and if applied locally it has a charming effect.

I admit that there is often harm done in using powerful local remedies. This is, however, no reason or sign that they should not be used, but rather that they should be used more judiciously. The boracic acid powder should not be used in too great a quantity, so as to plug up the tympanic cavity and the external auditory canal, for this would often bring about very serious symptoms, and may even be fatal to the patient if it remains for considerable time.

It may produce all the symptoms of Meniere's disease by

pressing upon the semi-circular canals through the fenestra-ovalis, or it may cause death by preventing the discharge of the purulent secretion, which forces the discharge to extend toward the inner ear and attack the membranes of the brain, especially the dura mater, and thus terminate fatally. The best way to apply the powder is by an insufflator. The quantity should be just sufficient to cover the exposed mucous membrane, and should not be left to remain longer than thirty-six hours, and great care must be taken to remove every particle. This powder, besides acting very powerfully upon the mucous membrane, has also the power of absorbing and disinfecting.

In chronic cases the mucous membrane becomes often so thickened as to fill the whole, or nearly the whole, of the tympanic cavity. When such a state of the membrane is present the discharge is usually very copious, almost equal to those cases where there are polypi in the tympanum. The remedies, nitrate of silver, sulphate of zinc and sublimate of mercury, applied locally once or twice a day, will often cause the membrane to go back almost to its normal state in from several weeks' to two months' treatment. The strength of these solutions depends entirely upon the changes which have taken place. They may be used from two to a twenty-grain solution. The sublimate of mercury from 1-5000 to 1-2000.

In case that granulations have sprouted up from the inflamed mucous surface, our object must be to destroy them; for we cannot expect to have the discharge cease until all the granulations have disappeared. Those remedies which have proved to be most successful in my hands are chromic acid, nitrate of silver and spirits of alcohol.

If the granules are very large I usually puncture them with a narrow-bladed knife, so as to unload them of the surcharged blood, and then apply a few particles of the chromic acid in the opening caused by the puncture. One week's treatment will often cause the granulations to die out. This, however, often causes severe pain, so that the patient feels uneasy. If so, the granulations may be touched with a strong solution of *Argentum nit.*

Great care and judgment must be used when applying these remedies, for they are liable to produce great reactions in a certain number of cases. If the tissues in the tympanic cavity begin to look very red and swollen after they have been applied a number of times, and if the patient begins to complain of an uncomfortable warm feeling and pain in the ear, it is best to stop their use until the symptoms of irritation have subsided. In the meantime one part of spirits of alco-

hol to three parts of water, or stronger if the patient can bear it, should be dropped lukewarm into the ear not less than twice a day.

In children with granulations in the ear I always begin with a solution of the spirits of alcohol, applied three times a day, after the cavity has been cleansed. If the solution is not used too strong at first, there will be hardly any pain.

The inflation in all these cases should be kept up for some time, even after the discharge has ceased, for adhesive changes and rigidity of the ligaments are liable to take place, which can often be prevented by proper inflation. There are few cases in which the discharge keeps on in spite of the most careful and persistent treatment. These cases are either consumptives, in which an irritation is kept up by the excessive breathing and continual coughing, or in persons of a strong scrofulous catarrhal cachexia, who are on the verge of running into phthisis pulmonalis. Even in these cases proper cleansing should not be neglected, and a well-selected remedy should be administered.

DR. B. S. ARNULPHY—I cannot but express my gratitude for all the practical points to be learned from Dr. Vilas's paper, and I am sorry not to have anything to say that would add to its interest, but I may, perhaps, be of service to some members of our society by drawing their attention to another source of injury to the eyes that, for not being external, is nevertheless positive and frequent. We carry it in our mouths and bite on it at every meal; of course I mean the teeth. As far back as 1876 I published, in Paris, a "brochure" on the "Abnormalities of the Wisdom Tooth," wherein I took pains to establish that the irregular development of that late comer in the field is not unfrequently attended with inflammatory accidents of the soft parts of the mouth and pharynx, sometimes of the maxillary itself, and I hinted at the possibility that the eyes might become involved in the process. Since then Prof. Galezowski (of Paris) has observed cases of ulceration and even necrosis of the cornea brought about by abnormal evolution of the wisdom tooth, where a timely avulsion of the organ at fault would have saved the eye.

Dr. Galezowski, in a remarkable clinical lecture, states and proves by dint of facts, that dental alterations, especially

caries, play a great part in the production of ocular diseases, generally stubborn in character. We already knew, from the researches of Claude Bernard and Brown-Sequard, that the fifth pair of nerves presides over the nutrition of the eye, and Trousseau, with his admirable clinical sense, had pointed out cases of typhoid fever where the cornea was ulcerated, and where autopsy had revealed lesions of the trigeminus. Now the teeth receive their nervous supply from the same source. It is, therefore, easy to conceive that an irritation originating in any of these osteids may travel up to the eye, and there create any variety of functional and organic trouble.

Among the common visual derangements accomodative asthenopia is the most troublesome, and at times very hard to manage. The Parisian specialist cites numerous instances where avulsion of a decaying tooth cured in a day asthenopia that had baffled treatment, glasses and all. This shows that accomodative asthenopia is not always as Donders believed, the result of a defect of refraction or of astigmatism. A reflex dental irritation may be the sole cause of it. Hence the necessity for the practitioner to be aware of such facts, to carefully investigate the mouth of every patient that comes forth with an ocular trouble, and should he recognize the cause thereof, to turn him to the dentist, unless, of course, the oculist henceforward should deem it fit to learn the dentist's trade for himself.

**HOT WATER AS A HEMOSTIC IN OBSTETRICAL PRACTICE.—**By SHELDON LEAVITT, M. D.\*—The past few years have brought some important changes in methods of dealing with serious hemorrhages, and of arresting passive oozing in connection with operative procedures, accidents, and morbid actions of various kinds. Within my own professional experience, surgeons relied mainly on very cold water, and the per-chloride or per-sulphate of iron, to arrest a flow of blood, for which ligation or torsion were not the remedies. Not many years ago ice, snow and cold water applications, or the still more heroic treatment by ice-cold sitz baths, were thought to be

\*This special paper was prepared in accordance with the vote of the society at its meeting in September.



among the best means for checking persistent uterine hemorrhages. On the contrary, the surgeon now has his pitcher of hot water at hand as a most useful adjunct in case of annoying bleeding, and would feel uneasy without it; while iron as a hemostatic is rarely chosen. The obstetrician no longer calls for balls of snow and pieces of ice with which to control a loss of vital fluid, but for a good syringe and plenty of hot water.

Hemorrhages from the uterus, in connection with miscarriage and labor, are often alarming, though it may be said to the credit of modern obstetrical science, in latter years they rarely terminate fatally. That eminent obstetrician and graceful lecturer, Dr. Blundell, tells us that he was called in one night to two women dead from post-partum hemorrhage. I venture to say that no obstetrician of recent practice has had a similar experience. For myself, I can say I have never witnessed a fatal case, nor have I seen one wherein the hemorrhage did not speedily yield to the measures employed.

There has been a steady decrease in the mortality arising from the causes under review, during the past half-century, and a study of the various factors which have wrought this blessed change would be both interesting and instructive. At some future time I may make this the subject of a report to this society; but it cannot be embraced within the scope of this paper. Yet, perhaps I may be permitted to say, that the practice now in vogue of following down and stimulating uterine contraction with the hand, has done more to work out excellent results than any other one thing; and now that so effective a remedial measure as the hot water douche has been added, the menacing danger formerly hanging over the puerperal woman, like a sword of Damocles, is almost wholly removed.

Cold water is an efficient hemostatic, but, in obstetrical practice, the cases to which it is suitable are quite uncommon. It was, and is, employed as an abdominal application, and as a vaginal, and even uterine, douche. In special cases where thorough refrigeration is deemed advisable, and reflex action is sought in response to sudden shock, some have ad-

vocated the pouring of ice water from a height upon the naked abdomen. To my mind such treatment, with the dangers and discomforts attending it, is scarcely to be preferred to the hemorrhage which it seeks to control. Women possessing great powers of endurance, and retaining a good degree of vital force, may bear it with impunity; but alarming hemorrhage does not occur in the robust, nor does it leave in many a sufficiency of vital warmth and energy to harmlessly react from such heroic treatment.

It follows, then, as a legitimate inference, that while cold water is suited to a percentage of cases, hot water has an immense advantage in being equally well adapted to all. Even though it fail to arrest the hemorrhage (a thing, I may say, which it rarely does), we can scarcely conceive it capable, when used with ordinary caution, of producing serious harm.

Personally, I do not hesitate to pronounce hot water the safest and most valuable hemostatic for uterine hemorrhages arising in obstetrical practice, which we at present possess. Following is one case out of many which exemplify the efficacy of this remedy in post-partum flooding:

On the morning of August 30, last, I was called by Dr. Barrows, of Woodlawn Park, to visit a woman in confinement with her first child. Arriving at the house of our patient, I learned that she had been in strong labor all night, and the presenting vertex was then lying in the pelvic cavity, moodily resisting uterine expulsive efforts. The forceps were applied, and delivery of a living child was soon effected without serious breach of continuity in the maternal soft tissues. The secundines were easily delivered, and the womb contracted with gratifying celerity and density. Soon, however, the case assumed a less encouraging aspect owing to the development of a copious flooding. I grasped the globe of the uterus with one hand, and pressed the cervix with the fingers of the other, and thus brought the hemorrhage under temporary control. I held the organ for some time, and indulged the hope that it would afford us no further trouble; but here again hope proved to be an illusion, for, on removing my hands, the violent blood-loss again set in.

Meanwhile, I had been provided with hot water, which I injected into the uterus with immediate relief of this threatening symptom.

We may take this for a typical case of moderately severe post-partum hemorrhage, and what was first done for its relief ought to be done for every case. That is to say, when hemorrhage sets in with unusual freedom, we ought, in addition to making the ordinary compression on the fundus uteri, to exercise counter-pressure with the opposite hand, and thus get absolute, but sometimes only temporary, control of the flow. When this fails to give permanent relief, remedies being meanwhile administered by the mouth, the time is ripe for resort to hot water.

This gives us a rule for its use in post-partum flooding, but does not apply to the hemorrhage, sometimes nearly as alarming, in connection with miscarriage. The serious floodings of labor at full term, and those of abortion, are quite dissimilar in point of time. That is to say: whereas, in labor at the close of mature pregnancy dangerous hemorrhage nearly always comes *after* full evacuation of the uterus, in miscarriage it usually occurs *before* the complete evacuation.

In a small minority of all cases is the blood-loss in connection with interruption of pregnancy in the early weeks sufficiently profuse to be dignified by the title "hemorrhage," and therefore requires no energetic treatment. On the contrary, cases of copious flooding cannot be said to be infrequent. In these latter instances the cardinal indication is to empty the womb, and when this is once done, the excessive flow will cease. But, if we find the os uteri too small to admit of safe interference with the retained secundines, or if there exist other strong contra-indications, then I say use the hot water intra-uterine douche.

Again, though as a rule excessive flow ceases at once upon entire evacuation of the uterus, there are cases in which it continues, and in these we will find an effective remedy in hot water.

• In "unavoidable hemorrhage," and in what is techni-

cally termed "accidental hemorrhage," I should look for little aid from water of any temperature. In these varieties of flooding I have never had recourse to hot water, and do not recall the recorded experience of any who have.

In brief, then, the hot water intra-uterine douche should be used in post-partum hemorrhage when manual compression is ineffectual; in incomplete abortion, when attended with too profuse flow, while the os uteri, by its slight dilation, forbids artificial evacuation; and after abortion, or labor, when too profuse flow continues. I should not omit to say, however, that the vaginal, instead of the uterine douche, is sometimes sufficiently effective.

One of the essentials to a safe administration of an intra-uterine injection is a good syringe. I have used the "bulb" syringe, but greatly prefer the "fountain," or some other instrument which acts on the siphon principle. The syringe should be either new or thoroughly clean and aseptic. If my choice were between an old syringe, the cleanliness of which could not be guaranteed, and the administering of no injection, I would say, "I will withhold the syringe and rely for help on other measures."

The water should be hot, as hot as can be borne, namely, 115° to 122° F. temperature; when of a lower temperature it does little good. The tube ought to be carried nearly to the fundus uteri and the stream given but moderate force. The quantity of water will be regulated by circumstances. In one case two gills may answer, while in another a gallon may be required. We commonly get prompt effects; but now and then relief comes slowly.

It is not always an easy task to introduce the tube, and in miscarriage it may be necessary to draw down the uterus to accomplish our purpose.

Very hot water produces its hemostatic effects in uterine hemorrhage not alone by local action, but also by virtue of reflex excitement. The primary effect on the blood vessels is contraction, and hence the prompt response usually obtained. The flow of blood ceases almost as soon as the stream of water strikes the fundus uteri, toward which it should be

directed. The calibre of both large and small vessels is at once diminished, thereby greatly diminishing the loss and bringing it within normal limits.

While this is the result usually obtained, doubtless it would be but temporary were not other and permanent action at the same time, and by the same means, brought about. Not only are the blood vessels greatly diminished in their carrying capacity by contraction of their circular fibres, but, through reflex action, forcible contraction of the whole bleeding organ is excited, and the alleviation thus rendered permanent.

Our time might profitably be spent in considering other uses of warm water, but I will not enlarge the scope and design of this report to include them. Hot fomentations, hot enemata and hot baths have been employed for the relief of pain, and the production of relaxation, from the earliest days of medicine, and could not now be spared from the sick chamber; but there is no demand for a recital of their excellent effects before such a society as that here met, and this is my excuse for silence concerning them.

You will kindly permit me to add one word more concerning the intra-uterine use of hot water in my particular specialty. I believe the day is not distant when we will make it a matter of routine to employ the uterine, hot water, anti-septic douche in the puerperal state, not only for the purpose of securing cleanliness, but also with a view to promoting physiological involution of the womb.

This report would be incomplete without an allusion to the dangers associated with the form of treatment herein recommended, and to these I invite attention:

FIRST: *The danger of septic infection.* Too much emphasis cannot be put on the necessity for scrupulous care to render everything which enters the vagina of a pregnant, parturient or puerperal woman thoroughly aseptic. Careless practice may here result most disastrously.

SECOND: *The danger of forcing fluid through the fallopian tube.* In women who have been delivered at or near mature gestation, the os uteri is widely expanded, and the

cervical walls flaccid, so that there is no obstacle to a prompt escape of the water as it is injected. After miscarriage the conditions are not as favorable, and caution ought to be exercised. If the os uteri be small, a double canula or catheter should be employed. The stream cannot safely have much force; and if the water does not at once begin to run away as rapidly as it is injected, irrigation should cease, and the channel for escape be made more patent.

THIRD: *The danger of introducing atmospheric air.* To avoid an accident of this character the syringe should be tested and the tube well filled before introduction. If the fountain syringe, or any similar instrument, be used, the reservoir of supply should be kept from getting empty. When the ordinary bulb syringe is employed, the vessel containing the water must have an abundance of the fluid to prevent the suction end of the instrument getting above the surface of supply.

VAGINAL HYSTERECTOMY FOR UTERINE SARCOMA (with specimen).—DR. R. LUDLAM gave a verbal report of a case of intra-uterine sarcoma occurring in a woman of sixty-four years, a patient in his clinic at the Hahnemann Hospital, and from whom he had removed the uterus *per vaginam* in the presence of one of the sub-classes. The extirpation was made without the use of any ligatures; there was no hæmorrhage, and now, at the fourth day, she is doing well, with a good prospect of recovery. The clinical history of the case, the lobulated form of the tumor, and the absence of a capsule, as well as the peculiar texture of the growth after being kept in alcohol, caused him to conclude that the case was one of the hard, and not of the soft or diffuse, form of uterine sarcoma. The specimen was passed around and examined by the physicians who were present.

NOTE.—A subsequent microscopic examination of this tumor by Drs. Bailey and Lyon, proved it to be a fibro-sarcoma. Their report says: "A section shows it to consist mainly of round and spindle cells, held together without any attempt at order, except that the spindle cells lie parallel to one another in bands which interlace irregularly."

## Hospital Notes.

### THE SKIN AND VENEREAL CLINIC.

#### SERVICE OF PROF. T. S. HOYNE, M. D.

October 23, 1888.—According to the plan adopted for the study of skin diseases, I shall present to you to-day all the cases of eczema in waiting. I have already stated that it is the most common disease met with, and I have explained to you the various forms of this eruption. The first case is

*Case No. 13507.*—This little girl, who has been before the class several times, has eczema pustulosum. The part affected is mainly the chin and face, although she has one patch upon the arm. Under the influence of *Hepar 30* the character of the discharge has changed from pus to that of serum. One week ago the backs of the ears become affected, and *Graph. 30* was prescribed. To-day she reports and looks much better, so the *Graph. 30* will be continued another week.

*Case 13502.*—This little girl is a sister of the last patient, and is two years older. From a former report we learn that ever since May, 1886, the face has been sore, with a discharge of pus of a very bad odor. At the commencement of the affection the discharge was watery, excoriating the surrounding skin. On August 21 she complained of sore throat, more or less chronic, which was greatly aggravated by taking cold. She has a sweet tooth, and likes everything very sweet. She is a very active child, and very quick in all her motions. All wounds of the skin heal slowly. *Hepar 30* benefitted her greatly. However, on account of constipation, *Nux 6* was given September 11, and *Nux 30* on September 18 and 25.

October 16. The eruption became much worse, and the bowels were again constipated. *Sulph. 30* was ordered, and to-day she reports decidedly better. The same remedy will be continued another week.

*Case 13515.*—This little boy, three and a half years old, comes in to get his discharge, as his eruption has entirely disappeared. A week ago, you will remember, his mother brought him in with eczema simplex located about the mouth and chin. It was said to have been produced by a fall, the child striking upon the chin. The discharge was acrid, producing an excoriation of the surrounding parts. *Arsen. 30* was prescribed on account of the character of the discharge, rather than *Arnica* for the injury, for the accident had occurred some time before.

*Case 13521.*—Stella, aged 22 months, has eczema rubrum on both cheeks, but rather more on the right cheek and eyebrow. Her mother says it began four months ago, but knows of no cause, as her other children are all healthy. The bowels are regular most of the time, but occasionally will be loose for a day or two. The child is cutting teeth. Teething is a quite frequent cause of eczema, and as the symptoms in this case are few in number we shall give her *Calc. carb. 30*.

*Case 13491.*—This young lady, sixteen years old, has two distinct diseases, viz., acue simplex and eczema simplex. She says she has been afflicted eleven years. Both her father and uncle have had a similar eruption upon the face. At one time her hands and feet were covered with an eruption, but at present the face is the only part affected. She complains of considerable itching, aggravated during the day. She has much backache, a sort of sticking in the back and frequent pains in the right side. The bowels are regular. The menses are not yet established. Complains of frontal headache, coldness of the feet, and says the urine contains at times a white sediment, and at others one of a pinkish color. The discharge from the eruption was at first watery, later thicker, and at present there is no discharge whatever.

The above is a statement of the case at the time the patient was admitted to the clinic. Dr. King prescribed *Lyc. 30*, and the menses became regular and normal. The skin symptoms improved somewhat under its influence. During the summer months the house physician prescribed *Puls.*



for the suppression of the menses, *Graph.* for the eruption, and *Sulph.* for constipation, which was quite obstinate. In September, when I took charge of the clinic, there was quite a discharge from the eruption of a watery character; the itching was very troublesome, aggravated at night and by heat. *Led. 30* continued for a few weeks benefitted her greatly.

October 23. She reports that she feels well in every particular except the breaking out, which is worse again. She thinks that the wet weather makes it worse. Scratching also aggravates it. *Rhus 30* will be given for a week.

*Case 13519.*—This young lady, who comes for the first time, has an eruption on the face, and she says that the entire scalp is covered with sores and scabs. The disease only began four or five weeks ago. The eruption on the face, you will notice, is papular, and the skin is full of black pores. A glance suffices to satisfy you that this is a case of acne simplex. There is no itching about the face.

What is the disease on the hairy scalp? The patient says the scalp itches excessively, and after scratching off the heavy, yellow scabs there is a watery discharge. At first she says the discharge consisted of thick, yellow matter, which dried into thick, yellow scabs, matting the hair, and the odor then was very offensive. The head itches most at night, and she cannot refrain from almost constant scratching. There is also a slight papular eruption on the back of the neck, extending downward, but no itching of the part. The patient evidently is of a scrofulous diathesis; the eyelids especially show this. Her digestion is perfect, the bowels regular, the menses normal, and have been ever since they made their appearance, at thirteen years of age. Her hearing is somewhat impaired, occasioned, she tells us, by a blow she received upon the ear eight years ago. Every morning she hawks up tasteless, thick, yellow matter.

In this patient, then, we find a combination of skin diseases. The acne papule does not itch as a rule, and the eruption about the face is free from this annoying sensation. The scalp does itch. In acne there is no discharge, even if the

parts are scratched. The eruption on the head does discharge, at times pus, at others a watery fluid. As the entire scalp is implicated in this patient, you are certainly justified in asking is this a case of seborrhœa and acne? Dry eczema of the scalp and seborrhœa are very similar in their general features, but when the scales are carefully examined, and the history of the case accurately determined, there need be no difficulty in deciding between them. The scales in seborrhœa are greasy, and tend to adhere closely to the scalp, although they may become loosened and fall upon the clothing. In seborrhœa we never have the history of a discharge, and itching, if present, is very moderate. Also the skin beneath the scale is paler than normal, whereas in eczema the integument is reddened. From the statements made by the patient, it is learned that the itching is excessive at night, and that there has been a discharge, and is now, whenever the parts are scratched, and the scales rubbed between the fingers have not a greasy feel. Hence this is not a case of seborrhœa, but one of eczema capitis and acne simplex. *Natrum mur.* 30 was prescribed.

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### THE CLINIC ON GYNECOLOGICAL SURGERY.

#### SERVICE OF PROF. LUDLAM.

The gynecological department of the college and hospital has furnished three regular, and sometimes four, clinics per week. The operations are made before classes of twenty senior students. The following notes taken from the clinics on gynecological surgery will be of practical interest:

#### CYSTO-SARCOMA OF THE LEFT OVARY—OVARICTOMY—RECOVERY.

—Case 20,259.—Mrs. H., of Conway, Kas., aged forty-five, was brought to the hospital by Dr. E. K. Thompson, and examined at the general clinic October 3. She is the mother of ten children, and first observed an enlargement in the left inguinal region seven years ago. Fifteen months ago the dropsical accumulation became so great that she was tapped,

and since that date she has been tapped ten times. At each of these operations two pailsful of fluid were taken. Five weeks have now elapsed since the last tapping. Examination discloses a solid tumor lying centrally and below the umbilicus. The surrounding fluid is evidently ascitic. There is also a sac which protrudes from the vulva, which is five inches wide and seven inches long, and which is evidently due to an inversion of the posterior cul-de-sac. She is very much emaciated.

The operation was made by Prof. L. in the hospital October 6. The ascitic fluid being disposed of, a tumor, which was partly cystic and partly solid, and of a dumb-bell shape,

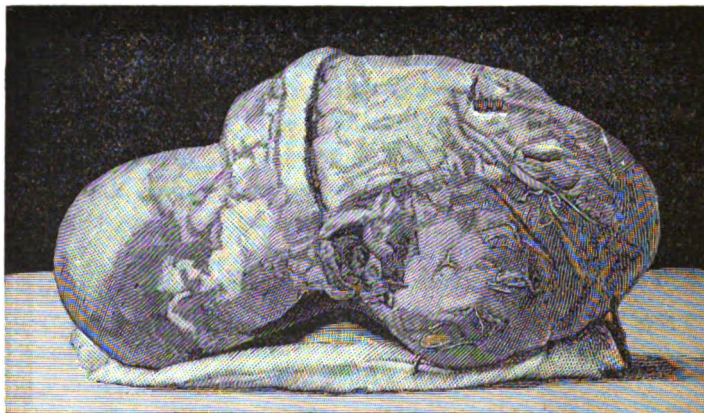


FIG. 1. CYSTO-SARCOMA OF THE OVARY.

lying transversely above the fundus uteri, was exposed and brought out through the incision. (See Fig. 1). This tumor weighed ten pounds, and was attached to the left cornua of the uterus by a very short and thick pedicle. The attachment was so short that it could not be clamped, and so fleshy that it was not safe to trust to the ordinary ligation. Two pins were therefore passed through the left horn of the uterus, and the rubber ligature applied, with the usual dry dressings. Nothing was done with that vaginal cyst, which afterward disappeared spontaneously.

Wednesday, October 31. This woman was again brought

into the general clinic. She is bright and in good spirits, eats and sleeps well. The upper part of the wound healed by first intention, but there has been considerable suppuration about the stump, which is now retracted. Her highest temperature was 102 $\frac{1}{4}$ , which was on the seventh day; and her highest pulse, at the same date, was 135. She has had the excellent care of our house physician, Dr. Stiles, and of her faithful nurse, Miss Sheppard.

November 4. She is well, and left the hospital for home a very happy woman.

REMOVAL OF THE LEFT OVARY AND TUBE, AND ALSO OF A SMALL, PAR-OVARIAN CYST.—RECOVERY.—*Case 20,267.*—Miss ———, æt. 25, unmarried, was brought to the clinic by Dr. J. P. Parmly, of Wisconsin. In January, 1886, she fell down stairs while carrying something, and to break her fall she grasped the baluster and wrenched her left side, from which she has suffered ever since. A great portion of the intervening time she has been confined to her bed; it was impossible for her to lie on the affected side, and very painful to use the left leg. The menses have been regular, but too copious, and accompanied by much pain of a cramp-like character. The abdomen has been painfully distended with gas, and the bowels obstinately constipated, and a movement is intensely painful. There has been a thin, watery and abundant leucorrhœa at times.

The *operation* was made on Sunday morning, October 7th. While the patient was being anesthetized in the ante-room, Prof. L. said that he had several reasons for calling the class of seniors together on this bright Sunday morning: (1) We have the Divine authority and example for healing the sick on the Sabbath day; (2) Dr. McDowell, who made the first ovariectomy on the first day of the week, always preferred to do so that he might have the benefit of the prayers of the good people in the churches; (3) with an engagement to make four ovariectomies within the next four days, I must do this work now or my friend Dr. Parmly will have to wait until the last of the week; and (4) this is the way that I have of cele-

brating my own birthday, the last one having been kept by making an ovariectomy in the Homeopathic Hospital in Minneapolis.

The incision was made through a very thick abdominal wall. The left ovary and tube were very adherent, but were drawn out, ligated, and cut away. (See Fig. 2). Beside the enlarged tube and the cirrhotic ovary a par-ovarian cyst, lying within the folds of the broad ligament, as large as an English walnut, was also removed. The peritoneum was closed with the continuous cat-gut suture, and the parietes with silver wire.

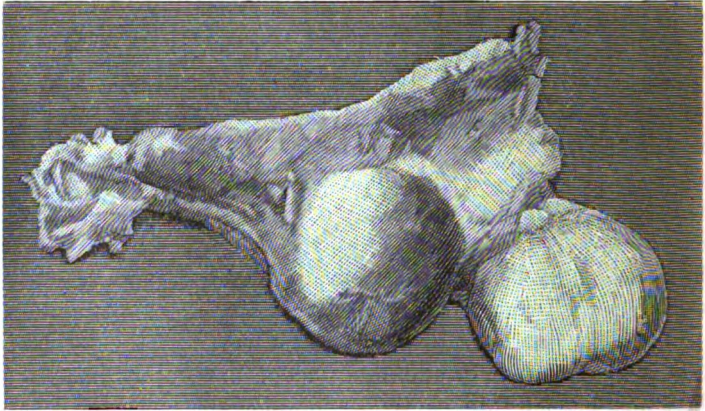


FIG. 2. SCLEROTIC OVARY, WITH A PAR-OVARIAN CYST.

October 24. This patient was brought into the general clinic and the wound shown to the class. She had entirely recovered without any marked symptoms. The wound had healed beneath the dry dressing without the least sign of suppuration.

November 6. She left the hospital to return home.

THE MORBID ANATOMY OF UTERINE AND OVARIAN TUMORS.—An attractive feature of this clinic is the opportunity given of seeing and studying the peculiar morbid anatomy of these tumors. Among the fresh specimens submitted to the class already during the present session are: (1) An old and very

tender multilocular ovarian cyst that was taken from a patient of Dr. C. N. Hazelton, at Morrison, Ill., the woman having made a good recovery. (2) A tumor removed at *post-mortem*, showing an extra-uterine pregnancy at the fifth month. (3) A fibroma involving the entire uterus and broad ligaments. In this case Prof. L. had made a laparotomy at the Homœopathic Hospital in St. Paul, Minn., September 20, but decided that it was impossible to remove the tumor with safety. The patient did well until the fourth day, when she began to have spells of suffocation. There were no other abnormal symptoms. These paroxysms recurred, and despite the best care terminated fatally on the sixth day. The specimen was carefully removed and kindly forwarded by her physician, Dr. W. S. Briggs. (4) The cysto-sarcoma of the ovary from Case 20,259. (5) The tumor, tube and sclerotic ovary from Case 20,267. (6) Two large multilocular ovarian tumors removed by Prof. L. in a double ovariectomy made October 6, upon a patient of Dr. J. F. Brown, of Jackson, Mich., and who, although the case was a desperate one, made a good recovery. (7) A double united ovarian cyst, with two pedicles and only one tumor, taken October 16, from a patient of Dr. J. C. Bates, of Spring Lake, Mich. Beside these formations the whole pelvis was filled with papillomatous growths of a highly malignant character, with fibrous and periosteal adhesions, which rendered their removal impossible. The patient died on the eighth day. (8) The uterus measuring five and one-half inches in length, with an intra-uterine sarcoma, and removed before one of the sub-classes by vaginal hysterectomy.

## Miscellaneous Items.

Here is another overgrown issue of the CLINIQUE.—There were no lectures on election day.—Prof. Hoyne, chairman of the Bureau of Skin and Venereal Diseases, will report at the next meeting of the Clinical Society, November 24.—It is proposed to make the *Hahnemannian Monthly*, of Philadelphia, for 1889, “the best medical journal in the land,” except the CLINIQUE.—Dr. H. R. Arndt, the worthy editor of the *System of Medicine* in three volumes, will spend the winter months and practice his profession at the Coronado Beach Hotel, San Diego, Cal.—There are over 200 first-class matriculates in the old Hahnemann this winter, and those who are really interested in the “higher medical education” should call and see how it is conducted.—Prof. Arnulphy has been appointed United States correspondent for *l'Evenement*, one of the most influential dailies of Paris.—Having succeeded in electing his candidate for the Presidency, Dr. D. S. Smith has gone to Washington already, but not for an office.—Prof. Shears is winning golden opinions in the surgical department of the hospital; ditto, Profs. Watry, Dunn, Bailey and others, in their respective spheres as clinical teachers.—The first of the Students' Receptions is announced for Thursday evening, November 15, at the residence of Prof. Leavitt, 148 37th Street.—Dr. Belle L. Reynolds is traveling in Italy and Spain.—The Bollens, of South Australia, have reached home safely.—A copy of the new journal issued by the Boston University School of Medicine is expected by the next steamer.—It is already too late for the dissatisfied students of other colleges to avail themselves of the superior clinical advantages of the “old Hahnemann” during the present winter session, and no doubt their case will prove an awful warning to others. *Vive la clinique!*—The delegation of our students which participated in the Republican procession of Saturday, November 3, did not forget to call upon Profs. Ludlam and Hoyne on their way home. *Selah!*

# THE CLINIQUE.

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## Original Lectures.

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### ON TRACHELO-BRONCHIAL ADENOPATHY FROM TUBERCULOUS INFECTION.

A CLINICAL LECTURE DELIVERED AT THE HAHNEMANN MEDICAL  
COLLEGE AND HOSPITAL OF CHICAGO, NOVEMBER 14, 1888,  
BY B. S. ARNULPHY, M. D., PROFESSOR OF PHYSICAL DIAG-  
NOSIS.

Having devoted several lectures to the theoretical exposition of the principles of Physical Diagnosis, I now feel justified in giving you a bit of practice. To that end I bring to your notice a case from my private practice, which I propose to study with you, as it is well adapted to bring into play those primary notions with which I have endeavored to make you familiar.

*Case.*—Mr. L. occupies quite a prominent position in his own town. Having noticed of late some unusual symptoms, he came to Chicago to seek my advice, and very kindly consented to come before you for examination, actuated by the desire to be useful to you, wherefore I am sure you will be grateful. He has a strong and well-tempered mind. He is not to be scared by what I am going to say. What he wants is the truth about his case, and therefore he dreads naught but the unknown.

Our patient is twenty-eight years of age, of rather slender but wiry build. Up to the past few weeks he has been a well man, engaged in active business, and has never been ill.

His family history is very satisfactory. The grandparents



died of old age. His father, who is in the audience, enjoys good health, and leads a useful professional life in spite of his sixty-six years. His mother is fifty-six years old, has had a small goitre since she was twenty, and has nothing to complain of except some stiffness of the fingers of her right hand, due to rheumatic gout. The patient's only brother enjoys excellent health.

Some time in April last he began to notice some hard and flat lumps that would form here and there in the depth of the integument. They first showed in the calves of the legs, then in the upper extremities, much more on the right side, and never affected either the trunk or the neck and face. These lumps presented this peculiarity, that they formed rapidly, became quite painful, assumed a slightly reddish appearance and felt warmer than the neighboring parts. After two or three weeks' duration they would melt away and disappear.

This symptom, more strange than troublesome, did not interfere with the patient's calling, so that he paid little heed to it; but toward the early part of August he began to observe a peculiar sense of fullness in the neck, accompanied by some flushing of the face. This latter symptom was exaggerated by exertion, excitement, and especially by stooping down or straining at stool.

It slowly kept on the increase, and about the beginning of September the neck showed decided signs of swelling. Eight weeks ago the patient was suddenly seized with an attack of coughing that lasted fully four days and four nights. The cough was dry, paroxysmal, harassing, provoked by a violent tickling below the larynx, worse at night. It stopped abruptly and has not returned. Nor has there been any cough or expectoration since. In fact, the only subjective symptom the patient is aware of, as far as the respiratory apparatus is concerned, is a slight shortness of breath on exertion.

About two weeks after that crisis, he observed that his face was swollen and puffy in the morning on first getting up. The swelling would gradually subside as the day wore on. It was more marked on the right side.

At the same time the patient was troubled with feverish attacks, recurring regularly two days in the week, with a rise of 2° F. and attended with a tired feeling, headache and dyspeptic symptoms. Quinine, taken at the dose of 25 grains per day, failed to control the fever, so that it was dropped. It would now seem as though the fever were inclined to remit of its own accord. In fact the thermometer has hardly indi-

ated a rise of half a degree during the past few days, and only one degree last night. The pulse is generally in the neighborhood of 80, pretty fair in strength and quality.

The last symptom that has developed within the past six days is a remarkable one. The right arm began to show signs of swelling, which has now assumed an oedematous character. It feels heavy, painful, numb and slightly warmer than the left. The right hand, however, feels colder. At the same time the patient notices that his voice is a little thicker. With the exception of the aforesaid symptoms, and though he has lost some ten pounds in the course of the last few months, the patient complains of no particular suffering; has a good appetite, a fair digestion, sleeps well, and is able to walk and to climb stairs without any special trouble, but the motion of the elevator makes him dizzy and faint; and he cannot stoop without experiencing that sense of unpleasant fullness of the neck and head. I will now ask the patient to stoop down; look at him when he raises his head again. You can see that the face is flushed with a slightly cyanotic tinge; at the same time you see the veins of the cervical region standing out, very plainly showing the knotty points of the valves.

I repeat that the patient's pathological record is a clean one. We have no history either of syphilis or rheumatism or scrofulosis to fall back upon. There are neither nervous nor vascular family antecedents. His habits have always been temperate. The case then stands for us to judge on its own merits.

Every point, therefore, that pertains to the personal history of the patient needs to be scanned closely. Here is a peculiar bit of family history which he has reported. Some fourteen months ago his wife's sister, aged eighteen, was taken to his house, presenting symptoms of hepatic abscess, with purulent stools, and of concomitant obscure lung trouble, that soon proved fatal.

A few months later the deceased girl's mother, who had nursed her in her illness, developed an ominous cough; then a bronchitis set in, accompanied by hectic and emaciation, night sweats, etc. About the same time the patient's wife was taken ill with suspicious pulmonary symptoms that brought her very low, but wherefrom she has since made a recovery. Last, but not least, our patient, some four months ago, first noticed the signs of his trouble.

Such is the clinical history of this case. It tells its own tale. Let us now proceed to the physical examination of the patient, and see what light we can gather from that source of information.

On *inspection* the first thing that strikes us is the peculiar intumescence which you observe at the root of the neck; it is pyramidal in shape, rather hard and brawny to the touch. There is some prominence of the cervical veins, and the superficial upper thoracic veins (external mammary) are quite apparent; besides there are here and there patches of minute purple varicose branches. The swelling of the face is still very marked; you see that it is more pronounced on the right side, thus giving to the face a somewhat asymmetrical appearance. The right upper eyelid is still puffy and half-closed, but earlier in the morning the patient could not raise it at all. To-night it will look almost normal. Now, look at the right arm. It is decidedly swollen, and pits on pressure. If we measure it by comparison with the left arm we find a difference in the circumference of from one to one and one-half inches. At the same time you notice a very slight cyanotic tint. When I first saw the subject, about six days ago, there was quite a depression in the right infra-clavicular region. On account of the swelling of the parts that has since taken place you cannot perceive it now.

If we resort to *palpation* we bring out the following points: We feel a very small gland in the middle of the right cervical region. By pressure over the site of the right phrenic nerve, at its passage between the insertions of the sternocleido-mastoid, we cause pain. We find the heart impulse normal, the apex-beat at home; we fail to discover any purring thrill or tremor anywhere about the precordial region, nor is there any pulsation or local expansion of any kind. On the other hand we find the vocal vibrations to be very distinct over the antero-superior regions of the chest.

By *percussion* we discover an area of dullness over the right infra-clavicular region, covering the manubrium sterni, and extending about two inches over the left side. The pleximeter-finger experiences a decided sense of resistance. Over the right upper inter-scapular region we recognize another area of dullness about the size of a dollar, and the ear applied to that point easily detects a *tubular breathing* both on inspiration and expiration, exaggerated vocal resonance and whis-

pered pectoriloquy. The breath-sounds are somewhat diminished on the right side, while at the corresponding apex the heart-sounds are distinctly heard by transmission. Both of the cardiac *bruits* are normal and well marked. But a soft systolic murmur can be heard below both clavicles.

Here we have a pretty good harvest of physical signs wherewith to construct a sound diagnosis, if we only succeed in interpreting them in the right way.

But let us revert to the symptoms, namely, to the swelling of right side of the face and neck, as well as of the right arm. They forcibly point to some kind of compression of the superior vena cava, or at least of the right vena innominata. Moreover, the inference is that the obliteration is incomplete, for if it were complete, or if thrombosis had taken place, we should have cyanosis and an œdematous swelling of the head and of both of the upper extremities.

Such, then, is the symptomatic diagnosis. But this is only the first step. We cannot rest satisfied with so little. The question naturally arises: "*Why is there any compression of the vena cava?*" Such is the pathogenic diagnosis we have now to elucidate, and here it is that the physical signs we have just made out come to our rescue.

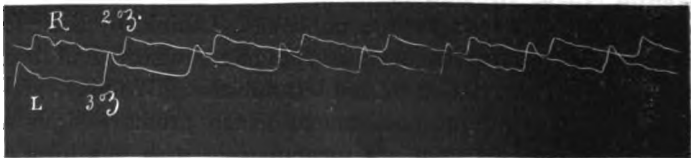
The heart, of course, is out of the question since we find it normal, and if it were diseased the consequences would be felt in the whole vascular system, and not only in one or two branches. Besides, the remarkable fact that climbing stairs hardly affects his breathing, while the motion of the elevator makes him feel dizzy, conclusively shows that whatever circulatory trouble is present is not due to a defect in the pumping organ, but to some sudden variation of pressure in the intracranial venous circulation.

Still a case is on record, published, I think, by King (of England), where signs of intra-thoracic pressure had been determined by dilatation of the left auricle. We may safely rule out such a unique occurrence. Such pressure signs as we witness in this case are incompatible with any form of pleuritic disease, or pulmonary consolidation, or pericardial effusion.

The fact is that a pressure of that description betokens some *abnormal intra-thoracic growth*. It must be owned that here we stand on very uncertain ground, for still another momentous question confronts us: "What is the nature of that growth?" Here we have to feel our way on the principle of *exclusion*. We know that many and varied are the causes likely to create pressure within the thorax. There may develop *vascular tumors*, such as aneurism of the aorta and of its branches, and aneurism of the pulmonary artery; there may develop *glandular tumors* of various kinds, *carcinomatous growths*, *cervical gummata*, *cysts*; there may gather *abscesses of the mediastinum*, inflammatory or ossifluent; or there may be *mediastinitis*, etc., etc.

Prominent among the aforesaid causes of pressure stands aneurism, both in point of gravity as well as of frequency.

Is it an aneurism that we have to deal with? In that connection we generally find a history of syphilis, or of alcoholism, or of rheumatism, or of violent strain, or of traumatism. We have nothing of the kind here. Aneurism develops mostly between thirty and fifty. Our patient is not yet thirty. In aneurism the pressure signs are not very marked, especially in its first stage, the tumor being soft and yielding; besides, among the first symptoms is pain, sometimes distressing, but we have none here. We have neither cough nor aphonia, frequent in aneurism. We have no double centre of cardiac pulsation, as we get in aneurism; we have no bulging or localized expansion, and, most important of all, we get distinct vocal vibrations over the seat of the dullness, which would not be the case in aneurism. Besides, here are the sphygmographic tracings, taken by Prof. Crawford, at both wrists.



They look pretty much alike. The slight difference in favor of the left tracing may be accounted for by an abnor-

mality in the distribution of the radial arteries in our patient, and at all events would be utterly unable to warrant even a suspicion of aneurism.

In favor of a *solid growth* we have, on the contrary, the marked venous engorgement, the extensive dullness over which no marked vascular sounds are perceived, the signs of superficial vascularity, the absence of pain, the tubular breathing and the increase of vocal resonance in the upper chest.

Next in the scale of probabilities comes the hypothesis of a *glandular swelling*. There is still much mystery about the lymphatic system. I have heard Billroth, in his clinic, say that we never can tell what a glandular swelling would turn out to be, even when it is accessible to the eye and finger. For instance, nothing is so obscure as the etiology of malignant sarcoma of the cervical glands, *alias* Hodgkin's disease. We have no clue to it yet. Some of the broad symptoms of that affection seem to exist in our case; still there are no circumstances to make it likely that this is a malignant growth. Besides, he has passed the period of life in which that disease is most frequent. And then our patient's blood seems healthy, and he exhibits no signs of even incipient cachexia.

The absence of outward glandular engorgement rules out *adenia* and *leukemia*. On the same principle we may discard the consideration of a cancerous growth. Besides, the occurrence is rare in itself.

It may be useful to remark, that while primary lymphosarcoma of the neck is more prevalent in childhood and adolescence, and preferably attacks the weaker sex, thus widely differing from aneurism, true carcinoma of the mediastinum resembles this latter affection both in point of time and sex.

Equally rare are the instances of *mediastinitis*, that is of inflammation affecting the connective tissue of the mediastinum, a few cases of which are described by Prof. Jaccoud, in his masterly clinical lectures. Mediastinitis may occur through the following mechanism: peri-aoritis, inflammation diffused through the connective tissue, periphlebitis, thrombosis, etc. Or it may be due directly to an attack of rheumatism. But in

that case there would be just as much pressure exerted upon the aorta as upon the other vessels, and the fact would be revealed by a slackening of the pulse. Here the pulse is quickened. While we feel warranted in ruling out this hypothesis, there is no denying that this new and yet ill-known variety of intra-thoracic disease offers considerable clinical interest.

The idea of an abscess cannot be entertained for one moment, so that we would finally have to fall back on the rarest class of mediastinal growths, that of cysts, acephaloid or simple. There are only two or three authenticated instances of such growths on record, that I know of. We had better lay that aside, and turn our attention to one hypothesis, which I would not have mentioned had it not been for the fact, singular enough, that two specialists of this city, whom the patient has consulted, have hit upon a theory to explain the nature of this case.

I refer to *Exophthalmic Goitre*. It appears to me that even a superficial survey of the symptoms of the patient shows how egregiously unlike those of Graves' disease they are. There is a total absence of the four cardinal symptoms of that affection; first, there is no goitre, as you may see; the swelling is at the root of the neck, not about the larynx; then there is no protrusion of the eyeballs, but swelling of the eyelids; besides, there is no palpitation; and finally, there is no anæmia. And how should we account for all the positive signs we have elicited, such as dullness, whispered pectoriloquy, venous compression, etc., by means of an affection which, until further notice, we are warranted in considering as a sympathetic disturbance? It would be idle to discuss a diagnosis that has no leg to stand upon.

By means of this successive elimination of improbable contingencies we have narrowed down considerably the field of investigation, and we are thus led, by a retrograde process, to the consideration of some glandular affection as being the cause of the mischief brewing here.

Such being the case, nothing could be more advisable than to throw a backward glance at the clinical history of our patient, in search of some guiding thread.

There is one symptom, in fact the incipient symptom, that must have struck you as strange and unusual. I refer to those lumps that ushered in the whole trouble. Judging from their feel, appearance and behavior, one is readily led to the conclusion that they were due to some disturbance of the lymphatic system, the nature of which is, nevertheless, I must own, pretty obscure. But the clinical fact is there all the same. How shall we interpret it? I am inclined to regard it as due to some central perturbation of the lymphatic circulation, repercussed on the peripheral network of lymphatic ducts, by obstruction or infection of some kind.

Is there anything in the history of the case that would point in that direction? It seems to me that there is. Only remember that girl who died in the patient's house over a year ago, having presented symptoms of abscess of the liver and of obscure lung trouble. Remember that all the members of the family who were living in that house at that time have since broken down in health one after another. First the mother of the girl, who nursed her through her illness, then the patient's wife, then the patient himself. If that does not sound like a history of infection, it looks very like it. It is at all events a striking pathological episode well worthy of our attention. Suppose this were a tale of tuberculous contagion all through. Tuberculous abscess of the liver is not an uncommon occurrence, and the infection arising therefrom is not less probable than that of the pulmonary form. If such has been the case, the atmosphere in the patient's house must have been for many months crowded with bacilli. They have dealt their blows right and left, and the measure of their evil work is to be found in the vital resistance of the contaminated inmates.

The patient made a gallant fight. No doubt the micro-organisms found their way through the aerial passages into the parenchyma of the lungs (right apex), where they contrived to set up their specific changes.

Having, as we may infer, first found a field unfavorable to their development, they began to travel along the easy water-ways of the lymphatics, and finally reached the tracheo-



bronchial glands (which are so many organic islands), where they settled and soon extended their domain.

It is, in all likelihood, from such a glandular enlargement that our patient suffers. Viewed in this light, the interpretation of his symptoms, subjective as well as objective, becomes very simple.

We have already referred to the significance of the lumps. The shortness of breath and the attack of coughing are to be attributed to a certain degree of pressure upon the extremity of the trachea. That pressure certainly affects the right main bronchus, as is shown by an array of positive physical signs: (1) Diminution of the breath-sounds in the right lung; (2) tubular breathing; (3) exaggerated vocal resonance and (4) whispered pectoriloquy in the right upper inter-scapular region, coupled with (5) a patch of limited dullness. The retraction of the chest wall in the right infra-clavicular region speaks of some collapse or compression of the lung tissue there. At the same time the predominance of the dullness over the right upper chest points in the favorite direction of the swelling. The change in the voice may be sign of a slight compression of the pneumogastric, while the same cause bearing upon the sub-clavian arteries gives rise to the systolic murmur perceived below the clavicles. There is no dysphagia yet, but the patient notices that, *when lying down*, eructation is difficult. As to the swelling of the right arm, neck and face, it clearly indicates the seat of the compression to be about the opening of the right vena innominata into the superior vena cava, and the fact that the swelling of the face is always at its worst in the morning, shows that the erect posture during the day favors the flow of the blood downward, through the obstruction, to the right cavities of the heart.

Now, if we bring together the history of the patient, the notion of glandular swelling to which we have come by the principle of exclusion, if we add thereto the precious sign of pain over the phrenic nerve at the neck by pressure, a sign that was first pointed out by Noël Guéneau de Mussy as characteristic of deep tuberculous adenitis, and if we take in due consideration the peculiar thermic ascensions the patient

has reported of late, we have enough to warrant us in formulating as follows our etiologic and final diagnosis: *Trachelo-bronchial adenopathy from tuberculous infection.*

Profs. Fellows and Crawford, who have examined the patient, take, I am happy to say, practically the same view of the case.

We have no possible means, in this species, of verifying the correctness of the diagnosis, as there is no free exudation that we could place under the microscope or inject into a Guinea pig. Besides, the microscope has made such an imperial failure of late, that perhaps we had better trust to clinical inferences only.

The disease of which I am able to show you to-day a remarkable example is one of rather infrequent occurrence, and therefore one that is comparatively little known yet. In the early part of the present century Andral first delineated the history of that lesion, expressing his doubts, however, as to the possibility of recognizing it during the life of the patient. You see that things have somewhat changed since, thanks to the enormous strides made by physical diagnosis. About the same period Louis, another famous pathologist, undertook to show, by persevering autopsical investigation, that tuberculous transformation of the deep lymphatic glands of the neck is by no means rare in children as well as in adults. But somehow or other these sound notions were neglected for a number of years, until Becker, Rilliet, Barthez, Richet, Le Roy de Méricourt again took up the study of the subject. Still the best, if not altogether the latest, work in that direction, seems to me to have been effected by my old and beloved master, the late Dr. Guéneau de Mussy, whom I have already cited with reference to that excellent diagnostic sign, namely, the pain by pressure over the phrenic nerve.

Now comes the thorny question of prognosis. Of course, if we could know what is the exact condition of the diseased glands, it would help us somewhat. You know what is the usual evolution of glandular tissue when invaded by tuberculosis. First, a diffused infiltration by *small leucocytes* takes place; then the characteristic *giant cells* appear; then *caseation* sets

in; then *the caseous matter breaks down* and the gland suppurates, or else it undergoes fibrous degeneration or calcification.

What is the stage reached by our patient? It is hard to tell. Still, judging (1st) from the recent date of appearance of the symptoms; (2d) from the fact that the glands are still enlarging, as testified to by the progress of the swelling of the face and arm; (3d) from the temperature, which for many days has reached no higher point than  $99\frac{1}{4}^{\circ}$ , the inference would be that no tendency to suppuration is yet exhibited, and that perhaps the glands have not yet passed the first stage, that of leucocytes.

Another point of interest would be to ascertain the degree of virulence of the infection itself. You know that there are bacilli and bacilli. They are not all alike in point of virulence. For my part, I think these are of a rather mild description. At all events, we must fight them at once.

The danger in the present case lies in three directions:

1. The enlargement may increase, with a corresponding increase in the compression of the neighboring parts.
2. The glands may suppurate and discharge into the aorta and branches, pulmonary artery, venous trunks, or into the trachea, or the esophagus, or the mediastinum, or the pericardium (?).
3. General infection may ensue from the scattering about of the germs brewing in the local focus.

Still, against tremendous odds, I am inclined to take a rather hopeful view of the case. My reasons for doing so are (1st) that the general condition of the patient is good; (2d) that the infection is yet purely local; (3d) that there is no sign of impending suppuration of the glands; (4th) that the temperature keeps relatively low; (5th) that there is no scrofulous taint in the blood.

Under such conditions it is not unreasonable to expect a favorable change from proper therapeutical interference. Of course, if the glands, instead of being buried deep into the mediastinum, were in any way accessible, we would either remove them or destroy them on the spot, and the cure would

be effected *ipso facto*. But no surgeon under the sun would be justified in such work. We must resort to safer if slower means. First, we advise the patient to relinquish his business, to take a needed rest, and seek an abode where he may find, with a moderately high altitude, a dry, bracing and equable atmosphere, as it is obvious that a bad cold, involving any inflammatory affection of the pulmonary apparatus, would prove a most unfortunate complication. To that effect also the use of Jaeger's sanitary woolen goods is highly commendable. The diet should be more vegetable than animal.

In order to bring about as rapid a decrease as possible in the size of the glandular growth *Natrum iodatum* will be given in nature, and I advise sub-cutaneous injections of *Arseniate of strychnine* and of *Eucalyptol*, with a view to checking all possible spreading of the infection by means of the small veins that creep around the diseased glands. If we resort to such measures, it is because we do not feel justified in taking any chances in a case of this nature, and because the true physician is in duty bound to apply those means which he deems best calculated to save or benefit his patients, as the case may be.

Still the main work will have to be accomplished by homœopathically selected remedies, and out of the many that suggest themselves in the present trouble, two come prominently to the front, namely *Silicea* and *Calcarea phosphorica*. I would give the former at the 200th, the latter at the 30th dilution, with an occasional dose of *sulfur* 30th, place the patient under the best climatic, hygienic, dietetic, and antiseptic conditions, closely watch his temperature, and hope for improvement.

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A LECTURE INTRODUCTORY TO THE COURSE ON  
PHYSIOLOGY IN THE HAHNEMANN MEDICAL  
COLLEGE AND HOSPITAL OF CHICAGO,  
SESSION 1888-89.

BY PROF. JOSEPH P. COBB, M. D.

(Concluded from page 393.)

How differently we start in our study of physiology than did the earlier students of this great science, when the brain

and its functions were unknown, when the heart was considered the abode of the soul; the spleen of the passions; the liver the center of circulation, and the stomach the *seat of life!*

What progress could we expect to make in six months were we handicapped in the start by such obstacles?

You, ladies and gentlemen, are the successors of a long line of students who have left their "foot-prints in the sands of time."

Over this road have traveled many thousand pilgrims, and among them the renowned masters of this science.

Vesalius, who defied the terrors of law and the horrors of superstition, who, at night, climbed the gallows for the first complete skeleton ever prepared in Europe.

Schwann, who, hemmed in by poverty, patiently worked day and night for years until he was able to demonstrate that important generalization, that the entire human body was built up of discrete particles of protoplasm called cells, each one of which had an independent activity.

Harvey, who first demonstrated the circulation of the blood. John Hunter, whose discoveries, both in anatomy and physiology, were almost countless. Eustachius, Fallopius, Sylvius, Willis, Malpighi, Albinus, Meckel and many others whose names you will constantly meet in your study of the nomenclature of the human body.

Let us glance a little more in detail at the earlier status of knowledge in this department.

Esculapius, deified by the Greeks as the God of Medicine, lived before the siege of Troy. Whether he was a Greek or an Egyptian has never been settled, and it is immaterial to us as all the information we have of his knowledge and ability comes down to us through mythological traditions. From the time of Esculapius to that of his eighteenth lineal descendant, Hippocrates the Great, the Father of Medicine, nothing which is authentic, or that can be called definite knowledge has been transmitted to us.

The Druids of early Gaul and Britain, the priests of ancient Egypt, the Lamas of Central Asia, the Vaidhyas of India, made pretension to medical knowledge and boundless skill; but their knowledge was mainly the knowledge of human nature, and their skill the skill in working upon the imaginations of a credulous and superstitious people. They depended upon amulets, talismans, charms, etc., to work cures. Of the structure of the human body we have no evidence that they possessed any definite knowledge.

The eastern Magi devoted some attention to medicine, and

the Seers, of Palestine, laid claim to skill in curing diseases as a part of their divine calling. It is true that much *mystical medical art* was developed in Egypt, Assyria and Greece, even more than one thousand years before the Christian era.

But when we speak of connected and reliable records of medicine and surgery, based upon anatomical knowledge, as they existed in early times, we find we are indebted first of all to the great Greek physician, Hippocrates. He lived about 400 B. C., and with him began the true history of medicine; yet he and those of his time knew but little of the anatomy and physiology of the human body; nothing of the nervous system, and but little of the true outlines of disease or the range and power of remedies. He regarded the body as composed of the four primary elements—air, fire, earth and water. He taught the doctrine of solids, humors and spirits; specified that there were four humors: the blood, phlegm, yellow bile and black bile; that disease was produced by a “coction” or ripening of morbid matters which were finally expelled at the crisis.

He knew that blood was contained in the arteries, for he gives directions for ligating them, but he also conceived that there circulated with the blood, an “aura” or spirit which returned loaded with the impurities of the body. He had no definite knowledge of the circulation, and was ignorant of the communication existing between the large vessels and the heart. Even his son-in-law and successor, Polybius, speaks of four pairs of large blood vessels in the human body, viz.: “The first pair leading from the parietal portions of the head down the sides of the neck and body to the outer parts of the thighs and ankles; the second pair being the jugular veins, leading from the sides of the neck to the inner side of the ankles and feet; the third pair leading from the temples of the head through the lungs, and there crossing each other, the one goes to the spleen and the left kidney, while the other goes to the liver and right kidney; the fourth pair of blood vessels lead from the throat and neck over the upper extremities and over all the front parts of the body.” Such were the anatomical views of the most advanced medical men in learned Greece to within three hundred and fifty years before the Christian era.

Bear in mind, too, that Hippocrates lived in the best and most prosperous period of Greece, and had for contemporaries such men as Socrates, Plato and Herodotus, the statesman Pericles and the sculptor Phidias.

Aristotle, a pupil of Plato, by his actual dissection of criminals, was the real founder of comparative anatomy and

zöology. He first assigned to the heart the origin of the blood vessels, but failed to distinguish between the arteries and veins. By him and such sages in medicine and philosophy as Dracho, Theophrastus and Praxagoras was the general stock of knowledge enriched.

Herophilus taught anatomy from dissections, and the charge is made that he opened the bodies of living criminals to discover the secret springs of life. He was destined to bear the disappointment of all physiologists who,

“By following life in creatures we dissect,  
We lose it in the moment we detect.”

He described the machnoid membrane, the sinuses of the dura mater. He first traced the nerves to their termination in the spinal cord and brain.

About 50 B. C. the methodic school was established, which taught that the human body was everywhere filled with minute pores, and that invisible corpuscles floating in fluid were constantly passing through these pores; that the food was first simply emulsified, then passed directly into the blood, where it was further refined, so as to pass easily through these filtering passages and thus act as a nutriment.

Erasistratus divided the nerves into nerves of motion and nerves of sensation; he described the tricuspid valves of the heart; first observed the lacteals in the goat, and also stated the use of the trachea to carry air to the lungs.

Galen, who lived in the second century of the present era, was a Roman, a most indefatigable worker and writer. His works, now wholly lost, were supposed to amount to 160, about fifty of which were on medical subjects. His original investigations were chiefly in the department of anatomy, and his discoveries were mostly in the muscular system. He showed that the vessels called arteries, though for the most part found empty after death, really contained blood in the living body. In the blood-circulation he was not much in advance of his predecessors. He placed the origin of the veins in the liver, and the arteries in the heart. He affirmed that the two ventricles of the heart communicated by holes through the septum which divides them. So paramount was the opinion of Galen that no one thought of disputing the assertion until Vesalius, in the sixteenth century, said there were no such holes. This one error, dogmatically followed so long, probably retarded the discovery of the circulation of the blood several centuries. Galen traced the current of blood from the liver into the right ventricle of the heart, and then through the left ventricle to the lungs; otherwise his ideas of the course of the

blood were confused. He made several discoveries in the nervous system. In respect to physiology, he speaks of the living body as a unit, though constituted of parts of organs, simple and compound, of humors and of spirits. He maintained the old Hippocratic doctrine of the four primitive elements, fire, air, earth and water, with their four qualities, the hot, the cold, the dry and the humid. He held that the brain is the seat of the rational mind; the heart is the seat of courage and angry passions; the liver is the seat of desires.

In the fourth century the motion of the pulse was attributed to the contraction of the left ventricle of the heart by Nemesius, and by some it is claimed that he discovered the circulation, but he failed to follow the course of the blood in the veins.

When Galen died all that was aggressive in medical science at Rome ceased, and as it decayed there it again revived at Alexandria, where it continued until destroyed by the Saracens.

In the year 312 Constantine the Great, by a decree, declared the Christian religion to be the faith of the Roman Empire, and together with the growth of Christianity went for some time the decay of medical science. The clergy gradually gained control of public institutions, and deprived all others of means of obtaining scientific knowledge; they gradually inspired an unalterable confidence in the potency of unseen spiritual forces personified as good and evil. The Jewish idea of demoniacal influences, and the Gnostic doctrine of preternatural interposition also assisted in totally overthrowing the science of medicine, and reducing its economy to the most abject dependence on divine manifestations.

Apparently there has always been a connection between the contemplation of man's relations to the unseen world and the practice of quackery in this.

Theology has ever been apt to run into superstition and to degenerate into abuse for the sake of power. This is but too faithful a commentary on the first fourteen centuries of the Christian era, during which the practice of medicine was chiefly confined to monks and anchorites. Some few brilliant exceptions there were of men who conscientiously devoted themselves to the alleviation of suffering. Not until the fifteenth century, however, was any real advance made in the science of medicine.

The invention of printing by Guttenberg gave a new impulse to study, and thus advanced all sciences. The revival of the study of classical literature also gave an impulse to the study of medicine, though it affected this science in a more slothful way than the others.



The real revival began with the appearance of Vesalius' Anatomy, which was published in the middle of the sixteenth century. This was followed by more correct and minute physiology.

He first described correctly the general osseous system; very accurately the muscular system; the *chordæ vocales* of the larynx; the glandular structure of the stomach. He also exposed the error of Galen respecting the apertures between the ventricles of the heart. He discovered the vena azygos, coronary arteries of the heart, and several other arteries. He first represented the cervical and sacral plexuses of nerves and the vermiform appendix.

Jean Baptiste Canani shortly after discovered the existence of valves at the opening of the vena azygos into the vena cava, but he did not interpret their use. This was left for Charles Etienne, who was a decided imitator of Galen.

Fallopium, Vesalius, Eustachius, and the other anatomists of the day, all denied the existence of the valves, and this alone may have prevented Vesalius from perfecting his studies of the arterial system, and realizing the general circulation of the blood.

Shortly afterward Michael Servetus recognized and explained the pulmonary circulation.

The ilio-colic valve was described by Roudelet.

The aqueduct of Fallopium containing the chorda tympani, the labyrinth and tympanum, and several muscles about the head and neck, the os hyoides and the lower jaw were described very accurately by Fallopium.

In this century also were described the copora arantii, the vidian canal, and the canal which leads from the third to the fourth ventricle.

The structure of the teeth was set forth; the peculiar arrangement of the glandular portions of the kidney was noticed. The thoracic duct was discovered and described.

The right function was attributed to the valves of the veins by Fabricius, another link which leads up to Harvey's work.

Nicholas Masson first described the reflections of the peritoneum as a shut sac, but continuous membrane, covering the abdominal viscera, which is the pons asinorum for many modern medical students.

In the early part of the sixteenth century Harvey announced his brilliant discovery, which no succeeding one can ever supersede or obscure.

Next came Albert Von Haller. He developed physiology and all that it signifies. His attention was directed especially to the nervous system, the functions and limitation

of the different classes of nerves. He arrived at the conclusion that muscle fibres can be made to contract independent of nerve fibrils (which has been the subject of much discussion).

Then followed Hunter, Cullen and Brown, to whom we are and always shall be indebted for many fundamental facts in this science.

In 1661 Malpighi, in examining the blood of the hedgehog, discovered the red blood corpuscles, and in 1673, Luenwenhoek saw and described them; while it was not until 1770 that William Hewson discovered the white corpuscles or the leucocytes.

Van Helmont first suggested the use of the balance, which Lavoisier at a subsequent period consummated. The use of the balance is now recognized as a necessary adjunct in the pursuit of any exact science.

It is to Lavoisier, too, that we are indebted for our fundamental ideas on the subject of animal heat. He found that the animal absorbed oxygen and gave out carbonic acid gas. This is essentially the process of combustion. It was Lavoisier's idea that this combustion took place in the lungs themselves. This point, however, was scientifically settled in the negative when Magnus, in 1845, discovered the gases in the blood.

The discoveries and additions which have been made to our science during this century will come more prominently before your notice as such in our future study, therefore I will not detain you to mention them at this time. To leave the subject here, however, is to break off at the time of its most rapid and interesting advance and to leave the history of the science very incomplete.

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## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

THE NOVEMBER MEETING.

The Clinical Society convened in regular session in Club-room No. 4, Grand Pacific Hotel, at 8:30 P. M., Dr. W. M. W. Davison, second Vice-President, in the chair. There were present about sixty members and visitors. Dr. A. A. Rowe, of Englewood, was proposed for membership, and Drs. H. N. Lyon, W. A. Dunn and Willella Howe were elected to membership. The hour was occupied with

### THE REPORT OF THE BUREAU OF SKIN DISEASES.

DR. T. S. HOYNE, CHAIRMAN.

THE PREVALENT ERUPTIVE FEVERS.—By DR. T. S. HOYNE.—  
In addition to other contagious diseases there are at present prevailing in the city three, if not four, of the eruptive fevers, viz.: Varicella, scarlatina and rubeola, with possibly here and there a case of rotheln. It is well to know what contagious affections one is apt to meet with, and thus to be forearmed.

The first disease mentioned, varicella, can be dismissed with a word, for thus far it has been, as usual, one of unusual mildness, and requiring absolutely no treatment; neither have there been seen any vesicles with a cup-like depression, similar to small-pox, to worry and confuse the easy-going practitioner.

Scarlatina, on the other hand, in certain localities in the city and suburbs, has been marked by unusual severity. In other words, the number of malignant cases in proportion to the number attacked, has been quite large, and the fatal cases no greater than might have been expected under the circumstances.

So far as my knowledge extends the malignant cases have pretty uniformly been marked by an unusual severity of the throat symptoms. The tonsils become so swollen that deglutition is greatly impeded. The exudation about the fauces is characteristic, and frequently covers not only the tonsils and fauces, but extends up into the posterior and even the anterior nares, giving rise to a discharge of acrid pus from the nostrils which excoriates the face. The fœtor from the mouth is almost intolerable.

Taking this statement of the character of numerous cases this year is it not probable that many of the so-called deaths from diphtheria were really due to scarlatina? The exudation about the throat, to a careless or negligent observer, resembles the diphtheritic deposit, and, when it is remembered that scarlet fever is sometimes complicated with diphtheria, it is not surprising that errors in diagnosis are not of unfrequent occurrence. This matter is referred to here on account of certain letters published in the daily papers reflecting on the medical attendant for not making a diagnosis at once, or for other errors. In these malignant cases the cutaneous efflorescence may be entirely absent; seldom is it a pronounced feature of the disease, and hence the throat symptoms may mislead for a time. Should death result in forty-eight hours or less the certificate is usually made out for diphtheria.

During the present epidemic, convulsions, prior to the eruption or subsequently, have not been noticed. Glandular enlargements of the neck have been observed on several occasions. As has been already stated, the eruption on the skin has been very slight, in two cases entirely absent from first to last. When death has not resulted in the course of a few days, convalescence has been tardy. Albuminuria, I have been informed, has been present in a small number of cases, mainly as a sequel. Fortunately the disease has not spread to any great extent, but has been confined to certain localities.

A more often met with disease this fall is rubeola. The number of cases has been more than double that of varicella and scarlet fever combined, even if we include every fatal case of diphtheria with the latter. All the cases, so far as I have

been able to trace them, have sprung from two of the public schools. It may be that the affection has now become so widely diffused through the community, that it can no longer be traced to its original source.

While measles is usually a very mild disease, requiring but slight medical attention, but plenty of good nursing, a number of the cases met with have been attended with serious symptoms. In two instances the malady commenced with a sharp attack of croup, frightening the poor mothers, and for a time misleading the doctor. In both of these cases, girls, one aged three years and the other twelve, the scrofulous diathesis was well marked. The children just mentioned were members of different families in the same neighborhood, and visited back and forth.

In another case the stage of invasion was characterized by convulsions of short duration, which the mother subdued by hot mustard baths, while waiting for the family attendant.

A very striking peculiarity of the present epidemic, however, is a wide range in the date of the eruption; seldom did it occur on the fourth day, the usual time in typical cases. In one instance the eruption was noticed on the second day, but in the majority of patients it was not observed until the fifth or sixth day, and once only, I think, as late as the eighth day, after a terribly fatiguing cough.

Another peculiarity, commented on by parents themselves, was the extreme mildness of the catarrhal symptoms. Seldom was the irritable, reddened and watery eye seen, and seldom did the patient complain of photophobia. Unless the patient was kept in a darkened room the photophobia came on in the course of four or five days.

So exceedingly mild were the symptoms in a number of instances that the boys wanted to be out of doors—not going to school, of course, but on the streets at play. In no one of these cases, however, was the cutaneous efflorescence absent; it was invariably the prominent symptom of the disease.

A boy aged twelve years came to me to be treated for lichen. After carefully investigating his symptoms I gave him *Ledum*. Ten days later he broke out with the measles.

His brother also came to me with lichen about a week later than he, received the same medicine, and ten days afterward he likewise came down with the measles. What connection, if any, the lichen or the remedy for it had to do with the measles I know not.

Thus far I have neither seen nor heard of a case of rotheln or variola in the city, although there are probably cases of the former which are pronounced measles.

There should be no real difficulty in making a diagnosis in either of the affections mentioned after the eruption has made its appearance, the characteristic appearance of the same alone deciding the matter. Prior to the eruptive stage there may at times be some doubt, although from the general symptoms one may form a tolerably correct opinion. It is only in malignant cases of scarlet fever without eruption that one may for a moment hesitate. The onset of the disease, with the vomiting and the high grade of fever, ought to decide.

In all the malignant cases of scarlet fever that I have seen the children were of a scrofulous diathesis.

*Discussion.*—DR. SHEARS—Although as a rule diphtheria and scarlet fever are not often associated together, there are cases in which it seems to me the two diseases exist at the same time. About a year ago I was called to see a patient who had been ill for twenty-four hours, and who was now covered with a scarlet rash. The illness commenced with vomiting, and was accompanied by high fever. For four days the case seemed a typical one of scarlet fever, at which time the throat symptoms became severe. Soon a pronounced membrane appeared, which extended up into the nose and down into the larynx, the patient losing the voice. During the progress of the disease the patient had albumen in the urine and almost total suppression, rheumatism, became deaf, abscesses formed in the ear, in the axilla, on the chest and in the neck, and finally the patient became paralyzed in all the extremities. In the course of several months the right side regained its natural powers, but the left still remains almost useless. I believe in this case the two diseases were associated and ran their course at the same time.

Drs. Andrews, Davisson and Hoyne also took part in the discussion, after which volunteer papers being called for, the following essay was read by its author:

THE PESTILENCES COMPARED.—BY DR. N. C. KEMP, OF CHICAGO.—Epidemics, contagion, infection, pestilence—what do we mean by these terms, and what are the different things that they signify? Not all contagions are epidemic: not all infections are contagious; nor are all epidemics pestilences; and of these latter the list is shorter, happily, in the modern world than it used to be in the mediæval and the ancient: for only three diseases are now recognized as true pestilences.

The eruptive fevers, like measles, scarlatina, small-pox and typhus, are both contagious and infectious; that is to say, they are propagated either by contact with the diseased person or diseased thing. Rabies, or hydrophobia, leprosy, syphilis, glanders, are contagious and not infectious. But all of these, in civilized countries, are now so far under orders to medical science, whether in the way of prevention or of cure, that they never break loose upon a large scale epidemic as they used to in olden times.

Before vaccination had been introduced small-pox in some epidemics carried off one-fifth of the entire population, but small-pox is now well under control, and the pestilences promise to be in course of time. Of those still unvanquished the first we will mention is the Oriental plague, or "black death;" second, the Asiatic cholera; and third, the yellow fever. Of these the first rages exclusively in the Old World; the last has mainly prevailed in the New World, while the second, the Asiatic cholera, setting out from its natural habitat in India, has deluged with its destructive waves the greater part of the habitable globe. The plague, as I say, has never been epidemic in America; but its natural history is so interesting that I give it a little space. Happily we are much less acquainted with it than with the other pestilences. There are not a few persons who think of it as being hardly a modern, or definite disease at all, like measles, or diphtheria, but as some antiquated and little understood visitation. It is, on the contrary, one of the best known diseases. The torrents of controversy that have raged for centuries about the questions of its origin, its essential cause, and the manner of its propagation are giving away at last to a pretty clear understanding of what the plague is, though no one has told us as yet how to cure it.

The plague is a malignant, contagious fever, characterized by buboes or tumors of the glands in the groins and armpits. It has been known from the earliest times. The Old Testament notices what was probably the ravages of this disease. Hippocrates describes it, so does an early Latin writer. In China, in 1333, it was said to have destroyed more than one-

fourth of the entire population. The same epidemic swept slowly down upon Western Asia, Arabia, Syria and Egypt. Thence it leaped upon Europe under the name of the "black death." It spread throughout the length and breadth of Italy, France, Germany, Denmark, Russia and England, and there it recurred at intervals until the year 1360. It destroyed probably 25,000,000 of people in Europe alone; it is impossible to estimate the extent or to imagine the horror of its ravages in Asia. Of all diseases the plague destroys the greatest number of lives during a single epidemic. Since the end of the seventh century, Europe has had but little serious visitation from it, though as lately as 1879 it was busy in Russia.

When will it come again? It is a question which no one can answer; but we know whence it comes and how it moves, and can make a pretty confident hypothesis as to what its nature is. Its origin is usually in the countries upon the eastern shores of the Mediterranean. Heat and moisture favor its development, and Syria is hot and moist in summer and Egypt in winter. In England the plague is the worst from the middle of July to the middle of October.

It prefers low ground, and even the lower parts of a given building.

In some epidemics it was called a disease "which would not take the trouble to go up-stairs."

There have always been found persons to deny the contagiousness of the disease. Dr. Whyte, a surgeon in the English army in Egypt in 1802, was one of these.

He rubbed the plague matter upon the insides of his thighs, and inoculated his wrists from a bubo. In a week he was dead, stoutly maintaining to the last that the disease was not the plague.

An unscrupulous Italian physician made experiments of this sort, but always took the precaution to make them upon other persons.

He diluted the pestilential matter with small-pox matter, with oil, etc. This compound he called his pomade. If a patient consulted him for an ophthalmia, he ordered him some of his pomade to rub on his eyelids; if another complained of pain in the bowels, he ordered it to be rubbed on his abdomen. In this murderous way he gave, it is said, the distemper to thirty persons. The Doctor escaped the executioner, but the Turkish Government seized the druggist who sold the "pomade," and cut off his head, and the progress of science in that direction was checked.

The cholera presents the most striking contrasts to the



pestilence of which we have spoken. It is an epidemic disease, which consists essentially in the discharge from the bowels and the stomach of the watery portion of the blood. Its natural and ancient habitat is the delta of the Ganges.

From this point it has diffused itself around a great part of the world during the past hundred years. Leaving India in 1818, it reached Arabia in 1821, Syria and Judea in 1822, Russia in 1823, and Germany and England in 1831. From England it was conveyed, it is supposed, by an emigrant ship to Quebec, in June, 1832. New York was attacked on the 24th of this month, and by the end of July it had reached Philadelphia. It appeared at Havana in February, 1833, and since that time it has been a familiar visitant in many countries. The mortality is extremely variable; much depends upon the strength and environment of the patient, and much upon the virulence of the epidemic.

The early part of any given epidemic is the most fatal time. In New York, in 1832, nearly 50 per cent of those attacked died. The cholera is an air-borne and a water-borne poison. Wherever found it is the worst during the hottest months. It shows no partiality of age or sex in its attacks. In England the percentage of deaths to cases from 1832 to 1854 was from 45 to 47 per cent.

What is the nature of this poison, one of the most fatal and most widely diffused of all the epidemics known to history? It has been the object of the most long-continued and patient research; and, in spite of the careful labors of the German cholera commission of 1884, it has eluded positive demonstration as yet. There can hardly be a doubt that the cholera poison is a germ of some sort, a spore of bacillis or bacterium that multiplies in the blood. But while we are reasonably confident that a bacillis is there, we cannot feel that it has been definitely singled out of that bad company of microbes which it frequents. The cholera remains a peculiarly fatal and intractable disease. It does not spread directly from the sick to the well. Hospital physicians and attendants are not often attacked; the disease seldom spreads from bed to bed in a ward; post-mortem examinations are rarely, if ever, a means of contagion. On the other hand, the disease lurks in things and in places; in the holds of ships, in clothes and bedding that have been used by the sick, and in ground, or the water which is contaminated. In other words, cholera is an infectious not a contagious disease. The distinction is not an idle one; it is, on the contrary, one of the utmost practical importance to those who have to do with the disease.

It tells them that it is not the persons of the sick, but the places and the objects that have been poisoned by the disease, that are the dangerous things. With proper disinfection and cleanliness the sick room of cholera is a safe place; and so is that of yellow fever, but only when at a safe distance from the spot where the yellow fever, is raging. But the sick room of the plague is most dangerous under any circumstances.

The pestilence which has had the most recent interest to us is the yellow fever. This is an infectious fever, characterized by the so-called "black vomit" and a muddy yellowness of the skin. Its habitat is the West Indies, where Columbus saw, and rather vaguely described, a disease which was probably yellow fever, and where the first recorded outbreak occurred in the year 1647; since then it has broken out in different places, and at irregular intervals, in the Western World. It has passed the barriers of the Atlantic at times, and has become epidemic in Africa and Spain.

As in the case of the other pestilences, its origin and its spread have nothing to do with cleanliness, though the disease, like any other, is the more prevalent and the more fatal among the poor, the squalid, and the badly housed classes. It requires a temperature of about not less than  $75^{\circ}$  to  $80^{\circ}$  Fahrenheit for its development, and it prefers low levels. It is, like cholera, a very portable disease; the infection is carried in clothes, in baggage, in ships. Nothing kills it but sharp cold weather, and plenty of it; and this often only scotches the infection. Usually after an epidemic in the South a certain number of cases will appear the next season. In Mobile, in 1842 and 1843, it hibernated during the winter, taking its half of the town each year "more deliberately than the army worm would eat through a cotton field." In New Orleans, as Dr. Warren Stone described it, the yellow fever would often "travel, like a tax collector, from house to house along a street for two or three weeks before it diverges."

In New York, in 1822, its measured progress was about forty feet a day, and the Board of Health put a fence around it in Rector Street, extending the inclosure every few days in order to keep the public out of the infected district. Outside of that district life was perfectly safe. For the disease is infectious, not contagious; it is not communicable from person to person, as in the case of the cholera; you may nurse the patient in your own house if you will take proper measures of disinfection and cleanliness. But mark this added measure of precaution: Your house must not be within the limit

of infection; you must get outside of that limit—a thing you need not do in the case of either the plague or the cholera. In fleeing from their houses, the people in the stricken Southern towns did the only thing they could do. But a removal into the suburbs is usually quite as efficacious as going a hundred or a thousand miles. The mortal microbe lives in the infected things and places; it is not blown by the wind or carried by the water like that of cholera; and as long as you keep out of its immediate neighborhood, you are safe. Its room is worse than its company; but you must be sure where the danger line is drawn, and this is not always easy to know.

The mortality may be averaged at about one-third of the cases, but it varies greatly in different epidemics. It is not always the greatest at the beginning of the epidemic, as is commonly the case with the other pestilences. This was true at Jacksonville during the past summer; as the disease advanced the ratio of mortality increased.

A contagious disease is one which travels directly from person to person, whether by direct contact, by proximity, or by inoculation. An infectious disease is one in which the microbe does not pass from person to person, but is carried round and distributed in and by other objects, as clothing, baggage, houses, ships. Such are our three pestilences, the plague, cholera and yellow fever.

Small-pox and the eruptive fevers are doubly communicable, for they are both infectious and contagious. Summing up the practical points: 1. If you are in a plague-stricken district you may stay there as long as you choose if you will shut up your house and hold no communication with the outside world. The microbe of the plague will respect your seclusion; but to touch a sick person or any infected thing, is death. 2. If you are near the cholera you may stay there without shutting up; you may live with the sick, even in a hospital ward, so long as you keep the place you live in clean; but to go into the infected place, whether house or ship, or to handle infected things, is death. 3. You must get away from the yellow fever; you may even allow the sick person to come to you with safety so long as you keep out of the infected region; but no cleanliness can make that region safe as long as the epidemic lasts. To go into that region is death. Such are the three great pestilences. There is really very little treatment for any of them; the most that can be done is to treat the symptoms and sustain the strength of the patient.

It is simply a question in any case whether the disease or the patient is the strongest. It still remains for some great

discoverer like Pasteur to isolate and cultivate the respective germs of these diseases as he has done in the case of the hydrophobia germ, and then to vaccinate for the healing, or rather, the protection of the nations.

*Discussion.*—Dr. HOYNE remarked that while he was greatly pleased with the paper he must dissent from the speaker's opinion in regard to the mortality of two of the diseases at least. Under homœopathic treatment the number of fatal cases of cholera was about one-half as great as under old school treatment. In 1854 Dr. Pulte, of Cincinnati, put homœopathy on its feet in that city, by his remarkable success in the treatment of this justly dreaded disease. Dr. D. S. Smith, of Chicago, if he were here to-night, would tell you of his experience. In fact, every homœopathic physician, who passed through the epidemics of 1854 and 1866, could point with pride to his record as compared with his allopathic neighbors.

Fear kills in cholera, and I was greatly struck with the way the French dealt with this malady in 1884. At that time cholera prevailed in Paris as well as in Southern France, and yet the newspapers, day after day, denied its existence in the city, thus quieting the public mind and sensibly diminishing the number of cases. Here our newspapers would get out extras every hour, frightening even the most sensible people into an attack.

In the yellow fever epidemics our Southern brethren have over and over again demonstrated the vast superiority of the homœopathic dose. The report issued by the profession of New Orleans two or three years ago, giving the number of cases treated, number of deaths, cures, etc., was greatly to their credit. It should be remembered that it is the first cases that are the most severe: as the epidemic progresses the cases gradually grow milder.

Further remarks in a similar vein were made by Drs. Crawford, Hall and Davison.

THE APPLICATION OF DRY HEAT TO DISEASED MUCOUS SURFACES.

—By permission of the Society, Dr. L. R. Palmer, of Minne-

apolis, who was present, exhibited his apparatus and made some remarks upon this subject.

CANCER OF THE RECTUM—EXTIRPATION.—At the close of the meeting Dr. Shears exhibited a specimen of cancer of the rectum. Three inches of the entire circumference of the tube was involved. The patient had survived the fourteenth day and was convalescent.

THE CASE OF THE LATE EMPEROR OF GERMANY AND OF DR. MACKENZIE.—BY DR. B. S. ARNULPHY.—There is not, perhaps, under the sun a process of thought that is so philosophical as that involved in clinical work; one that requires so much of close thinking, of logical earnestness; one that calls forth from the depths of the inner man so much of all that is there in a potential status of keen insight and clear perception; one, finally, that involves, at certain times, more tremendous consequences in objects of world-wide interest.

The henceforth famous case of the late Emperor of Germany and Dr. Mackenzie brings these points into vivid light, and a few words of comment on the yet absorbing topic may not be amiss in the CLINIQUE. So much less so in view of the fact that the whole issue hinges on a few clinical points, the wondering nations listening from the amphitheatre, while doctors quarrel in the hemicycle.

I have carefully revised the elements of the ringing dispute, and while weighing the arguments on either side, and noticing the passionate comments, *pro* and *con*, diffused by the press at large, I could not help marvelling how easily men are apt, when brought face to face with some conspicuous event, to take a biased view of things; how seldom ideas, when aroused and flying thick in the air, tend to seek their level, but will heave into mental snow-drifts here and there under the stormy breath of feeling. In the present instance it is curious to watch how the dispute from a clinical one has widened into an almost national feud between Britons and Teutons.

Now that the autopsy of the patient has revealed beyond a doubt the nature of the case, convicting Mackenzie of error, and vindicating the diagnosis of the German physicians, it seems to me of interest to draw the moral of this dramatic tale.

I imagine Dr. Mackenzie's position to have been this: When he was called in consultation in May, 1887, we may believe his statement, that he knew nothing of the case. He

was confronted with peculiar circumstances liable, we must own, to embarrass even a more clever man than he. The case, in itself, was not an easy one, by any means. The appearance of the growth in the larynx had no definite character at the time.

The only significant facts at all about it had to be gathered from its clinical history, and from the physical examination of the parts. They were, (1) the rapid re-appearance of the growth after it had been partially destroyed; (2) the incipient loss of mobility of the left vocal cord.

Any clinician, in ordinary circumstances, would certainly have entertained a strong suspicion of malignity, and would have advised the immediate removal of the growth. In the present case there can be no doubt but the only comparatively safe thing to do was to incise the thyroid cartilage from without, and to remove the growth with a portion of the surrounding tissues. The danger resulting from the operation of thyrotomy, at that stage of the disease, is not necessarily greater than that which besets ordinary tracheotomy, when performed by a skillful surgeon. The total excision of the larynx is a different thing altogether. Such a wise and well-indicated operation as Gerhardt had planned and prepared would, in all likelihood, have resulted in preserving a very valuable life, and the world would be better for it, in many ways.

The profession would, at all events, have been spared the disgraceful squabble that has been waged over the corpse of an unfortunate, heroic and big-hearted man.

But Mackenzie failed to see the clinical facts in their true light, or at any rate, unduly undervalued their importance. While trying to arrive at the philosophy contained in the facts, with a cool head and an indulgent eye, and to analyze the mental process under which the Scotch specialist must have labored, I am led to suppose that had he had the case in charge from the beginning, he would, almost without a doubt, have drifted into the same inferences that slowly forced themselves upon Gerhardt's mind, and which enabled him, at an early date, to form a correct diagnosis. Instead, thereof, when Mackenzie reached Berlin, May 20, 1887, he found himself surrounded at once by an atmosphere laden with heavy responsibilities, besides bristling with predetermined and therefore offensive ideas, for minute preparations for the intended operation had already been made under the supervision of the Crown Princess in person.

Now let us take a glance at the man. Mackenzie is short, slender, wiry and nervous. He was fatally bound to react

against the pressure of the medium wherein he found himself immersed. So did he. After the first examination of the Prince's throat by Mackenzie, the doom of the former was sealed. This was indeed the psychological moment of the Prince's life. Explain the thing as one may, I take it for granted that, under the stress of circumstances and of the awful consciousness of his responsibility, Mackenzie must have been a victim to a phenomenon of cerebral refraction. Things appeared to him as they were not. His fine judgment was distorted. Had Frederick been a simple farmer Mackenzie would have seen right, and perhaps rescued him from trouble. One of the privileges of social greatness is to be prepared to die of it. "*Ceci tuera cela.*"

Then it was that Mackenzie in his perplexity fell back upon microscopical examination to settle the diagnosis. This was a great clinical blunder, and it teaches the medical world a lesson at the expense of an imperial life that was paved with good intentions. One error will beget another. To rely on such test in such a case was plainly trifling with human life. That much has been clearly demonstrated.

When once started on the wrong track Mackenzie clung to his views with a John Bull tenacity, in spite of evidence, until it was too late to do good.

In all this, serious as the mistake was, is the mistaken man to blame?

Philosophically speaking, no; because the man was not himself. A mental squint, against which he was powerless, decoyed him into error, and his reactive, fighting impulses tied him up thereto. Nothing is so difficult as to be one's self in every critical circumstance of life. Anger, love, passion, anxiety will bewilder and estrange man to himself.

I assume, of course, and I truly believe, that Mackenzie was in earnest, and I scorn to revamp the degrading theory according to which the Scotch physician consented to prostitute his medical honor to a political scheme.

For what would be thought of a physician, possessed of the confidence of a family, who would find it fit to neatly despatch the husband in order to enhance the social condition of his widow?

Such a bold theory, if it were acted upon at all, would make one shudder with the recollection of the ghastly shadow of Count Ugolins, in Dante's *Inferno*, lurching off his sons' brains with the devout purpose of preserving their father's life.

Having thus endeavored to throw a glimpse of psychological light on Mackenzie's conduct, the fact remains that in

spite, and I should say on account, of his captious book, he has made for himself a name as a poor clinician (in the species) as a stubborn highlander, as a stinging, if not venomous, pamphleteer, and finally as a business man, of whom any Board of Trade would be proud.

After all, it is but human to err. Men are frail things, "reeds that think," says Pascal. Of course, but alas! how often do we think right? And are we always responsible for not thinking right? We are the toys of circumstances even when we believe that we are sporting with them. As it is, I fail to discover a more comprehensive epitaph to be graven on the mausoleum of the unfortunate monarch, whom Mackenzie calls "Frederick the Noble," but whom posterity shall remember as Frederick the *Badly-taken-care-of*, as this: "*Errare humanum est!*"

LAWSON TAIT ON MEDICAL BOYCOTTING.—This eminent gynecologist, who, as everybody knows, is a master of vigorous English, is also possessed of such liberal views as do him great credit. We give space to a single paragraph from his recent letter concerning the proposed admission of the neighboring homœopathic physicians to the advantages of the Midland Medical Institute:

"All positive knowledge which we possess in medicine is limited to fields which are as common to the homœopaths as they are to us, and it is clear, therefore, that in this stupid schism we are only following the example of the theologians, who are always most positive and most quarrelsome on those subjects regarding which they have the least positive information. In days gone by this spirit ruled humanity so completely that we used to burn those who did not share our ignorance, and the tendency to persecute would seem scarcely yet to have died out, for it crops out in all regions where exact knowledge is deficient. But neither persecution nor exclusion will advance knowledge, nor will they cloak ignorance. Therefore I protest against this attempt to excite one of the worst feelings of our nature by holding up a rag which was red thirty years ago, but which has now lost all its color."



## Hospital Notes.

### THE GENERAL SURGICAL CLINIC.

#### SERVICE OF PROF. SHEARS.

REPORTED BY C. F. MENNINGER, CLERK.

**RIGHT, OBLIQUE, INGUINAL HERNIA—INJECTION—CURE.**—*Case 19, 165.*—Mr. B., aged twenty-eight, was sent to the hospital by Dr. A. Schmidt, of this city. Seven years ago he was examined for admission into the German army, and was rejected because of hernia. Since then it has gradually grown, until now it is the size of an apple. It can be held in place by a truss, but the pressure is a constant annoyance, and he desires a cure. He has expended much time and money in consulting and following the treatment of advertising specialists in St. Louis and this city without relief.

Prof. Shears advised and made the operation known as Heaton's, which consists of injecting into the ring and canal a fluid preparation of *Quercus albus*. The following points were emphasized: (1) The needle should be introduced perpendicularly to the abdomen exactly over the center of the external ring, and not follow the finger which has entered the ring by invaginating the scrotal tissue. (2) The needle must be passed up the canal to the internal ring, and the entire canal bathed with the injective fluid. (3) Care should be taken that the fluid is not injected into the tissues around the external ring, as it is of no value in producing a cure and may result in the formation of abscesses.

The operation caused but little pain, and resulted in the production of a mass of indurated tissue in the canal. The patient remained in bed for two weeks, at the end of which time he was allowed to continue his business. The ring was closed. The hernia has not re-appeared at present writing.

**VESICAL CALCULI—LITHOTOMY—RECOVERY.**—*Case 19, 167.*—Mr. B., aged seventy-two years, sent to the clinic by Dr. McDowell, of Rockford, Ill. The patient, who looked very aged and feeble, had been suffering from bladder troubles for more than eight years. During the early part of his trouble he was treated for cystitis, but latterly he has been under treatment for hypertrophy of the prostate. This being incurable he was about to be left to his fate, when he came under the notice of Dr. McDowell, who sent him to the hospital for

examination. For more than a year the patient has been unable to pass the urine without the catheter. After its passage he is seized with a spasmodic pain which lasts for ten or fifteen minutes, and is of great severity, the patient groaning and rolling about in agony.

Examination with the sound gave unmistakable evidences of stones, and an operation was determined upon. By means of the left lateral perineal operation the bladder was reached and four calculi removed, the largest weighing over one ounce. On account of the pronounced venous oozing a shirted canula was introduced into the wound, and compression made with plugs of absorbent cotton.

During his remarks upon the operation Prof. S. called attention to the importance of examining, by means of the sound, the interior of the bladder of every patient who presented symptoms of difficulty in urinating. If such were the rule instead of the exception this patient would not have been permitted to go eight years without relief. Every case of difficulty in urinating in a man over sixty must not be hastily ascribed to hypertrophy of the prostate, and treated by prescribing a catheter. Within the last year three cases similar to this one had been operated upon by him for calculi, in every one of which the patient had been treated, for a greater or less time, for hypertrophy of the prostate.

The patient made a good recovery, the wound being kept open for some time, in order, by perfect drainage of the bladder, to cure the pronounced cystitis.

**SUPPURATIVE ARTHRITIS OF THE SHOULDER JOINT—NECROSIS OF THE HUMERUS—EXCISION OF THE SHOULDER JOINT.—Case 19,177.** From Dr. G. F. Contant, La Salle.—D., aged fifteen years. Two years ago this patient had an attack of rheumatism, affecting the various joints of the body. The disease finally settled in the shoulder joint, and after several weeks abscesses formed and discharged. Since that time there has been considerable pain in the joint, and a gradual increase in size. Examination showed the shoulder joint much enlarged, particularly on its anterior surface. This protuberance was traversed by large veins, giving the appearance often seen in cases of malignant disease. Indeed, a diagnosis of sarcoma had been made by one surgeon and amputation advised. Two fistulæ exist, one on the anterior surface and one on the outer wall of the axilla, both converging toward the head of the humerus, and each about three inches in length. The joint was ankylosed.

Prof. Shears advised excision of the shoulder joint, ex-

plaining to the patient's friends, who had expected amputation, that excision would give a useful arm, and was much to be preferred. The joint and diseased tissues were exposed by the single longitudinal incision as recommended by Langenbeck. The head and two inches of the shaft were found to be diseased, and were removed by the saw. The sinuses were



FIG. 1.



FIG. 2.



FIG. 3.

thoroughly cleansed with the sharp spoon and a Schede dressing applied. The first dressing remained for one week; at second dressing, on the fourteenth day, the drainage tubes were removed and the patient permitted to use the forearm. At no time was the temperature above 100°.

The patient is now able to raise the arm in such a manner as to place the hand on the head (Fig. 3), and has a useful arm.

The cuts, figures 1 and 2, show the amount of bone removed, but are somewhat too regular in outline to represent the actual condition of the diseased bone.



## Miscellaneous Items.

The next regular post-graduate course in the "old Hahnemann" will open February 25, four days after the Commencement, and continue four weeks.—The second edition of Prof. Leavitt's *Obstetrics* is promised for June 1.—The *Transactions of the American Institute for 1888*, a fine volume of 820 pages, is out promptly.—The old Hahnemann Institute is in good working order this year.—Edwin E. Hills, 70 State Street, Chicago, is the agent for the sale of the famous Clysmic Spring water.—The overflow of material in the Woman's Department of the Hahnemann Hospital has necessitated the establishment of another regular weekly clinic, to be held by Prof. Bailey on Fridays, at 10.30 a. m., which will be devoted to *Uterine Therapeutics*.—Mrs. Dr. Margaret J. Reynolds, formerly of Albany, N. Y., has removed to Richmond, Ind.—Faulkner's *Hom. Physician's Visiting List for 1889*, from Boericke & Tafel, is out in good season, and, with its excellent repertory, is really invaluable.—The second students' reception came off at the residence of Prof. Ludlam, December 13.—The new Boston journal, the *Medical Student*, is a clean, clever, practical sheet that promises to do good service.—Our old friend, Dr. E. V. Van Norman, has removed to the Hotel Florence, at San Diego, Cal.—The "Misrepresentations of Homeopathy," a new pamphlet by the untiring Dr. Thomas Nichol, of Montreal, suggests the enquiry that, if the commandment had read, Thou shalt not bear false witness against homeopathy, or against those who practice it, who can say what its growth might not have been?—Our readers will sympathize with our friend, Dr. C. M. Dinsmoor, of Omaha, in the sudden death of his excellent wife.

*Valedictory*.—This issue closes Volume IX of the CLINIQUE, and we beg to thank all of our friends for their kind interest and kinder words in approval of its non-partisan and straight-forward clinical course. (The phrase may be trite, but the feeling is sincere). From the very first its list of subscribers has increased and its influence has spread until with a host of earnest physicians it has become an indispensable auxiliary in their daily work. It has already published nearly five thousand pages of original matter, with clinical cases and papers from the college, the hospital and the clinical society. Its future is assured, and, as heretofore, it will continue to appear on the 15th of each month. Whoever is in arrears is kindly requested to forward his dues to Prof. Bailey, No. 3084 Michigan Avenue, without delay.

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# THE CLINIQUE.

A MONTHLY ABSTRACT OF THE CLINICS AND OF THE PROCEEDINGS  
OF THE CLINICAL SOCIETY OF THE HAHNEMANN  
HOSPITAL OF CHICAGO,  
ETC., ETC.

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# THE CLINIQUE.

VOL. X.]

CHICAGO, JANUARY 15, 1889.

[No. 1.

## Original Lectures.

### ON GYNECOLOGICAL SURGERY.

EXTRACTS FROM THE CLINIC ON GYNECOLOGICAL SURGERY IN  
THE HAHNEMANN HOSPITAL, OF CHICAGO, HELD BY R. LUD-  
LAM, M. D., PROFESSOR, ETC.

*Laceration of the uterine cervix, the perineum, and of the recto-vaginal septum, of ten years' standing. A modified form of Tail's operation for the latter with a perfect result.—Case 20275.*—Mrs.——, married, aged 34, has had two children at term, the youngest of which is now 10 years old. She has had three miscarriages at about the fifth month since the last child was born. The cervix uteri is the seat of a stellate laceration in which the lateral rents extend almost to the vaginal roof. The perineum has been torn through, and the recto-vaginal septum also for about three inches from the anus. For ten years she has not had the slightest control of the passage of fæces or of flatus during either the day or the night. The upper part of the vagina is greatly relaxed, and the region of the bladder is very sensitive.

The first operation, hysterotrachelorrhaphy, was made before a sub-class of twenty students, October 20, 1888. Professor L. stated that it was the worst case of a stellate os upon which he had ever operated. The wound was closed with five deep silver, and a number of superficial sutures.

November 5. The sutures were allowed to remain longer than usual because of the return of menstruation, but they were removed at this date. The result was perfect.

November 10. The operation for the closure of the rec-

to-vaginal rent by Tait's method was made in the presence of another sub-class.

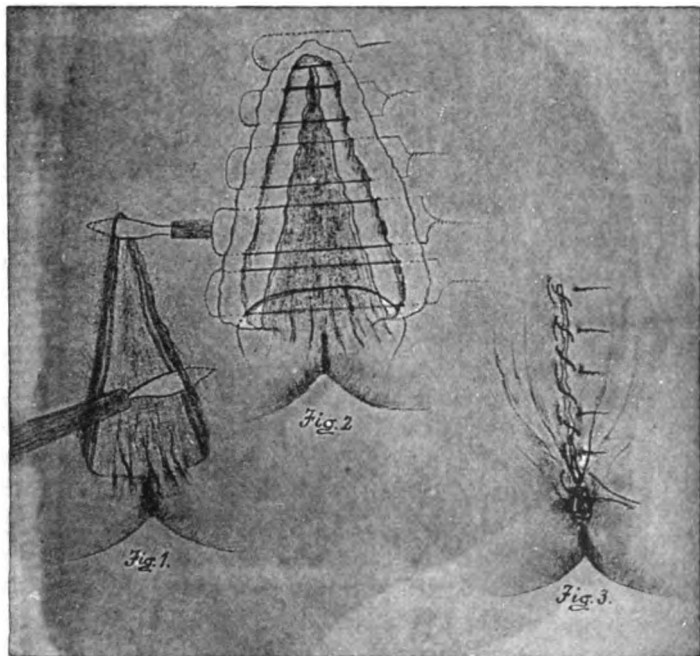
November 24. The sutures were taken out and the wound was found to have healed throughout, resulting in a closure of the rent, with the restoration of the complete control of the sphincter ani.

Concerning this patient Professor Ludlam made the following remarks in his general clinic: "You will remember this case as that of a poor woman who, because of injuries received at the birth of her child ten years ago, was entirely deprived of the proper control of the bowels. Not only has she suffered all that time from fœcal incontinence, but the flatus also has escaped whenever it chanced to pass into the rectum. Moreover she was what the French call a *monotréme*, for there was but one common opening for the rectum and the vagina, the stools escaping through the vulvar outlet.

You saw the  $\Lambda$ -shaped rent that extended for three inches along the gut; and your attention was especially called to the atrophied condition of the cutaneous and the perineal tissues. There was no perineal body left, nor was there anything out of which we could make one without serious damage to the ischio-rectal region. We therefore had to be satisfied with merely restoring the form and function of the intestine, and with repairing the wall that naturally separates its lower extremity from the vaginal canal.

To fill this important indication when the tissues are so scant is not always an easy matter. In the old way of operating I do not hesitate to say that in this case the result must necessarily have been a failure. We may sometimes bevel off the edges by way of freshening them when the laceration is not extensive, and when the deeper stitches through the adjacent parts can be depended upon to keep the lips of the wound in apposition, but it will not answer in such a case as this. Indeed, in all cases where the recto-vaginal septum is torn the best and most satisfactory way of vivifying the surface is to split its margins, as was first practiced by Lawson Tait. This expedient is facilitated by the ease of access of the edges of the wound,

and the good result is all the more certain because the rectum is so large that its caliber will not be impaired by the size of the flaps. The splitting may be done, but not at right angles, with a narrow bistouri, or with a pair of scissors ; (Fig. 1.) and the hemorrhage controlled by sponging with hot water.



Figs. 1, 2, 3. Steps of the operation.

By this method there is no removal of tissue, and the parts can be placed in so natural a position that they will readily heal. Moreover, by the plan you saw me practice, the splitting of the wall of the bowel is done in such a way as to secure a solid and firm, but not a thin or flimsy flap ; for, instead of splitting along the mesian line of the torn margin, I prefer so to direct the knife that the upper, or vaginal flap, shall be much the thicker of the two. This is the first of my own modifications of Tait's operation for a tear in the recto-vaginal septum. You have seen how well



it has worked in this instance, and I have had the same result in other cases.

My second improvement is to place all of the sutures except the lowest one so that they can be tightened transversely, each counting for two, and all of them so looped a the side as to give a splint-like support to the flaps when they are in apposition, (Fig. 2.) There were five of these double sutures, (which really counted for ten,) that were introduced in this case. They were of medium silver wire, were passed through the line of reflexion of the flap, and, after they were twisted, the edges of the valves were secured by the continuous stitch with the juniper-oil catgut. (Fig. 3.)

The special advantages of this mode of operating—and it is suited to a great variety of cases of perineal rent—will strike you as practical. When the vaginal flaps are lifted and coapted the rectal lips revert, or fall together, and do not need to be stitched, especially if the margin of the gut has been split in the manner that I have described. The perfect apposition of the denuded surfaces on the vaginal side, and which is so indispensable in plastic surgery, is easily secured in this way. If the rent has extended through the sphincter muscle there is also a greater certainty of bringing its torn ends (not edges) carefully together by this than by any other process. Since the sutures pass through the mucous surfaces only, and not through the integument, there is a greater freedom from pain than after any modification of the "butterfly" method. Besides, the wound can easily be cleansed, the bowels can be kept open with impunity, and, in case it becomes necessary to repeat the operation, no harm will have been done through the cutting away of the narrow tissues, for nothing has been removed.

Our friend, Prof. Comstock, of St. Louis, who frankly states that he first saw this operation made in my clinic,\* has very properly taken our medical teachers and writers

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\* The *Clinique*, vol. ix., p. 196. That patient was  $\text{æt. 55}$ , and the rent had existed for thirty-nine years. The result was perfect.

generally to task for neglecting it.\* He says: "I never take up a new work upon gynecology without at once looking for some mention of this operation, but with the exception of one English author, Arthur W. Edis, M. D.,† I have never seen it mentioned." It is no small praise of this method to say that Prof. Comstock resorts to it in preference to any other in all of his cases to which it is adapted.

Now, I will venture to say that there is not in this whole city a happier woman than our patient, who goes home tomorrow to bless the benevolent ladies who sent her to us, and the resources of an art that has relieved her of a disgusting infirmity. In the olden time the martyrs used to die, but in our day some of them survive long enough to find a means of relief and of rescue. It is possible that this very case will help you to help others in a similar way.

*Cervical fibro-myoma simulating inversion and procidentia of the uterus. Case 20,293.*—Mrs. —, married, aged 52, has had eight children and four miscarriages. She passed the climacteric two years ago. She always menstruated too often and too freely; nursed all but the last child, and the menses always returned when they were a month old. She had no milk after the last child was born. When she was about two months pregnant with her last child, which was eleven years ago, she discovered a tumor protruding from the vulva. The growth was not sensitive, but she could walk very little, and could replace it herself. The child was born at term, and the labor was easy. When the babe was two months old she lifted a feather bed which caused the tumor to protrude suddenly, and further than ever before. She replaced it immediately. The prolapse of this growth is always followed by exhaustion, trembling, and in twenty-four hours by vomiting.

About seven years ago she passed a polypoid growth, which was followed by a hemorrhage of four days' duration. A year later she passed a similar though smaller one, which was also followed by hemorrhage. During the last two years the growth has enlarged to about three times its previous size. It is retained in the vagina with difficulty, and only

\* *The Medical Record* for February 11, 1888, page 170.

† *Diseases of Women, including their pathology, causation, symptoms, diagnosis and treatment*, 1882, page 445.

by using a sponge as a support. Within the last year its surface has become abraded and more or less ulcerated. The discharge from the vagina over this growth is at times profuse, and now and then excoriating. She frequently notices a thin, starch-like, watery discharge from the vagina. Blood often oozes from the surface of the growth when it is down. It is not sensitive, and she does not know when it is touched. There is no pain connected with the ulceration, although there have been ulcers of the size of a dollar.



Fig. 4. The excised cervical fibro-myoma.

This is the kind of a case that would puzzle you in private practice. For several years it has been under the observation of a number of experienced and capable physicians and surgeons, and they have differed in their diagnosis. Some of them have decided that this tumor, which protrudes from the vulva, and which is so plainly visible to the class, is the uterus in a state of procidentia. Others insist that it is the inverted womb. I believe that both

parties are wrong, and that none have reached a correct diagnosis. However, there are two good reasons why we should not be too positive, or hasty in our opinion: (1) A surgeon of excellent repute in an eastern State has examined this tumor repeatedly, and declared most positively that it was an inverted uterus; and (2) there is a clinical precept that we ought to follow in this, as in other doubtful cases: "Take care, or you will find what you are looking for."

Upon inspection you observe the form of this tumor, which is pyramidal, and which looks very much like the uterus with its neck, or narrowest portion downward. You can all see what resembles the button-hole os of a woman who has borne one or more children. But, suppose the sound would not enter, and that after trying to pass a delicate probe you should find that this seeming orifice, much as it resembles the os-uteri, is only a sulcus, or cleft, in the mucous membrane. This is what I have already done. It is impossible by the most delicate manipulation to introduce either of these instruments, and I am, therefore, confident that this is not the uterine orifice. The natural conclusion, in the absence of all the signs of cervical atresia, is that this cannot be a case of procidentia.

It will be more difficult to determine whether it is a case of uterine inversion. The shape of the lowest part of the tumor does not favor that idea; nor does the fact that it is easily replaced within the vagina. The patient has passed the climacteric, and there is no history of a menstrual exudation from the mucous membrane investing the tumor. The only way to settle this question is to interrogate the pelvic organs by local and physical examination. I will first straighten this uterine sound, and then pass it along the urethra and into the bladder. If the fundus and body of that organ have been dragged down by this tumor, the instrument will take the same direction that I have shown you it does in a bad case of cystocele. For in complete inversion of the uterus the bladder is upside down, and lies on top of the tumor. And so it does, likewise, in a real case

of procidentia. But, here you see the sound has passed straight into the bladder, behind the symphysis pubis; its point is directed upward and forward so that I feel it over the pubis, and its handle is depressed toward the floor as far as it can be by reason of the tumor. So, therefore, whatever it signifies, the bladder is *in situ*.

Some of the most reliable signs of inversion are obtained by examination per rectum. On passing the index, or the first two fingers, through the sphincter ani, if the womb has been inverted, we may recognize a constricted portion which corresponds with the neck of the organ; and, by pressing forward through the recto-vaginal septum we may more or less distinctly feel the outline of its upturned and funnel-shaped orifice. In some cases this condition is so pronounced that advantage has been taken of it as an aid in pushing the inverted fundus through the cervical ring. I have also made such an examination in the case before you, and can assure you that these symptoms are altogether lacking. If it were not so we might pass the sound, or the catheter, into the bladder, and turn its point toward the rectum, where, if the uterus was inverted, it could readily be felt the same as in examining for congenital absence of the womb.

But what of the uterus itself? In the phraseology to which you are accustomed in this clinic, let us see if, like the bladder, it too is "at home." On applying the "touch" in front of the tumor I can detect what seems to be a rudiment, or a mere relic of the upper margin of the os-uteri. Below it is a sort of groove which leads up to it and along which I shall try to pass the sound. If it enters without force, takes the natural direction, and more especially if it can be felt through the abdominal parietes, the same as if this tumor was not at the vulva, we must exclude the possibility of uterine inversion. Here it is; the instrument has passed without obstruction, with its concavity forward, to the normal depth of the organ, and I can readily feel its point through the abdominal wall. This explains the occurrence of a periodical, muco-purulent discharge which

the patient says has escaped over the anterior surface, and not from the neck of the tumor.

But, suppose that having failed to find sufficient evidence by the search for the womb with the sound, after having also failed with the vesical and the rectal exploration, what other diagnostic expedients would have been available? We might have made the exploratory incision, and, passing the finger through the abdominal opening, have felt for the fundus of the womb, as recommended by Dr. Lusk; or we might have tried the more ticklish test of making an incision into the tumor itself, as practiced by Dr. Mundé, in search of its capsule, if it had one. In this case, however, these expedients are not necessary.

With this disclosure there is reason to believe that the tumor in question is a morbid growth of some kind, and that in all probability we shall be able to rid our patient of it as soon as we have decided upon its origin, nature, and point of attachment. But until that is done our diagnosis is incomplete.

It therefore remains for us to decide whether this neoplasm, which feels like a fibroid, originated as an intra-uterine, an intra-cervical, or as an extra-cervical growth. In case it once occupied the uterine cavity its presence in the vagina and outside the vulva must have caused expulsive pains, and more or less menorrhagia; and its escape through the dilated os-uteri would narrow its pedicle and leave it in large part, if not wholly, surrounded by the cervical ring. Moreover, in one whose vagina was capacious, and whose perineum was not intact, the form of the tumor would have been globular and not pear-shaped.

Intra-cervical polypi of a fibrous character are rarely so large, are always hemorrhagic, with labor-like pains, have sessile or broad-based attachments, and never appear at the vulva unless the uterus is there also, as we now know it is not in this case.

Extra-cervical fibroids that are larger than a walnut or a lime are almost never seen by the gynecologist. They are round, firm, sessile, of slow growth, non-sensitive,

benign, and harmless, except as they may press upon the neck of the bladder when they happen to be located on the anterior lip of the os-uteri, or interfere with the expansion of the cervix in labor. They are easily disposed of by enucleation.

Now, here is no well-defined cervical ring, nor even a small section of one. This tumor has no pedicle. While the uterus is nearly or quite as high as it should be, this growth lies between the thighs, whenever the patient sits or stands erect. There is no history of labor-like pains, or of menorrhagia, connected with its development. Our patient is positive that it was present in the vagina during her last pregnancy, and that it did not interfere with her delivery. Beside all this I can feel that the growth is attached to, and includes all the posterior surface and lip of the uterine cervix, extending from that peculiar groove or channel along which I passed the sound a little while ago, nearly to the roof of the vagina behind.

In differentiating between inversion or procidentia of the womb and fibrous or myomatous tumors that lie within the vagina, or without the vulva, you should not place any very great dependence upon the single test of their relative sensibility. For in a chronic case of inversion, or of extreme prolapse, the exposure of the surface of the tumor to the air may have destroyed its susceptibility to the action of irritants; and foreign growths that were not sensitive at first, or naturally, may become so finally. In recent cases we might perhaps learn something by sticking a needle into the tumor, but in this one, which is ten years old already, it would be of no practical use.

November 24, 1888. The operation was made before a class of twenty senior students; but while the patient was being anæsthetized in the ante-room, Prof. L. said this was a more serious case than it might appear to be to those who were present. For some of the most distinguished surgeons and teachers have committed the error of cutting off the uterus when they firmly believed that they had to do with a fibrous growth, or polypus; and others have vainly

attempted to reposit such a tumor because they mistook it for a displaced or an inverted uterus. There are numbers of such cases on record, and we do not want to swell that list.

The different modes of excision were briefly discussed. Of the various forms of ligation, that by the rubber ligature is best; but they are all slow and painful and beset by the risk of sepsis. The Pacquelin cautery, especially if the scissors attachment is used, will answer very well, but there is great danger of burning the surrounding tissues. There is only one objection to the galvano-cautery which is that if, as sometimes happens, there is one or more large arteries in the center of the tumor, there may be a troublesome secondary hemorrhage. If the tumor is firm, with a well defined capsule, it may be incised and the contained growth turned out. But the ease with which the encapsuled fibroid is enucleated varies in different cases, and it may be necessary to separate it from its bed with the spoon-saw, the handle of the scalpel, or with the fingers. The *écraseur* is likely to injure the bladder or the neighboring parts. I have found that a very good way, if the growth is large, is to throw the wire loop of this instrument around the base of the tumor and so constrict it as to control the hemorrhage, and then to cut it away. The common chain *écraseur* will crush and compress, and then break before it will separate most fibroids with a broad and very firm pedicle.

Everything being in readiness the first step was to seize the remnant of the anterior lip of the cervix with a small volsellum, to draw it down as far as could be done with safety, and to give it into the hands of an assistant. Then the base of the tumor was crossed with a large pair of Péan's lock forceps, but it was so thick and broad that this instrument was changed for a strong Spencer Wells' pedicle forceps, which was securely fastened and given to another assistant. The tumor was then deliberately cut away with the serrated scissors, which secured a practical torsion of the vessels as the separation was effected. The



stump retracted, and the pedicle forceps soon slipped off, but the margins of the wound were at once secured and the bleeding arrested by means of a number of small hemostatic forceps, which were allowed to remain until after the patient was put to bed.



Fig. 5. The same laid open.

[The tumor, of which an excellent representation from a photograph is given in Fig. 4, measured six inches in length by three and a-half in breadth at its widest part, and the portion of its external surface which had been most

exposed to the air was as if covered by epidermis. Fig. 5 shows the tumor after being laid open and also its encapsulated fibroid.]

November 28. Mrs. — is doing well. There has been no hemorrhage, or fever, and the offensive odor of the discharge was easily controlled by mixing Listerine with the vaginal douche which is given twice a day. The stump was afterward dressed with the watery extract of calendula applied directly by a cotton tampon.

December 5 (Wednesday). The patient walked into the general clinic. She feels well in every way, and will return to New York in a very few days.

*Amputation of the uterine cervix for a vegetating epithelioma. Conservative precautions.*—Before excising the cervix in a bad case of cancer at his clinic on January 12, Professor L. said that he had decided the patient should inhale chloroform instead of ether, because she had some trouble with the kidneys, and the urine was still albuminous, a condition which must always be looked for in cases of this kind. There was evidently some deposit around the supra-vaginal, or abdominal cervix, which hindered the descent of the womb toward the vulva, and which might explain the renal mischief through an involvement of one or both of the ureters, for an ascending nephritis is an early consequence of this form of peri-uterine infiltration. And not only does it contra-indicate the employment of ether as an anæsthetic in pronounced cases of cervical cancer, but it is also a bar to the performance of vaginal hysterectomy if the lesion is an old one, or has already extended to the vaginal roof.

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## Clinical Society Transactions.

JOS. P. COBB, M.D., SECRETARY.

DECEMBER MEETING, 1888.

The Clinical Society held its regular monthly meeting in Parlor 44 of the Grand Pacific Hotel, at 8:30 P. M., December 29th, 1888. Dr. W. S. Gee, Vice-President, occupied the chair. There were present just fifty members and visitors, an unusual holiday attendance. Dr. A. A. Rowe, of Englewood was elected to membership, and five new names were proposed for membership. The report of the evening was made by

### THE BUREAU OF OBSTETRICS.

DR. SHELDON LEAVITT, CHAIRMAN.

DR. LEAVITT introduced his report with the following remarks: The Bureau of Obstetrics esteems it an honor to make the excellent paper of our well-known and highly regarded friend, Dr. Comstock, the chief one of the occasion; and whatever else may be submitted will grow out of the suggestions therein contained.

There are several minor points worthy of separate consideration, but the main features are *occipito-posterior positions* and *episiotomy*. The former of these I would like to discuss at length, but shall refrain from doing so. Later in the meeting I may offer a few thoughts on the subject.

CASES OF LABOR WITH THE OCCIPUT SITUATED POSTERIORLY.—BY T. GRISWOLD COMSTOCK, A. M., M. D., PH. D.—*Case III.*—Mrs.——æt, 24, primipara, in good health, was taken in labor at full term, October 23, 1888, and attended by Dr. Goodman. Presentation recognized as the vertex, with normal pains, and the membranes rupturing spontaneously, early in labor. After the pains had contin-

ued some sixteen hours, the head well down below the brim, and no advance being made with each pain, Dr. Goodman applied the forceps, but without result, being unable to move the head. At this period of the labor, I was called in consultation, and found the head well down upon the perineum. The head seemed impacted, and was in no way influenced by the pains that were strong and vigorous, and I could not seem to move it by the touch, when made during the interval of a pain. The reason of this was, that the occiput was situated posteriorly. I then tried the forceps, but could not move the head, or bring it out of its position, so as to deliver it over the perineum. I then applied one blade of the forceps to the side of the head and tried to make rotation, but without effect. We then concluded to wait and see what nature would do. In the meantime the woman was becoming exhausted; the sounds of the foetal heart were very faint, and finally could not be heard. We then found that our only resort was to perform craniotomy and remove the child. With the approval and at the request of Dr. Goodman, I accordingly proceeded to make this operation, and with his assistance delivered her of a large-sized male child. The patient, as Dr. Goodman informed me, made a slow recovery, caused by the sufferings endured during the lingering labor, from the impacted head.

*Case IV.—Occipito-posterior position in a married woman sixteen years old, primipara, and husband aged eighteen years.—Mrs. W——, taken in labor November 1, 1888, at full term, with strong pains and a vertex presentation diagnosed. The waters were evacuated early in labor after puncturing the membranes, and the pains continued to be very active for some twenty hours; attended by Dr. Bahrenburg, who, finding that there was no advance, applied the forceps, but without any result. I was then sent for in consultation, and found the young woman suffering greatly and showing signs of exhaustion. Upon a careful examination, I found a posterior-occipital position, with head well down in the cavity of the pelvis, and already*

pressing upon the perineum. I tried with the vectis to rectify the position, but found it impossible, as the forehead and occiput both seemed to be fixed and immovable. I then tried by means of the straight forceps to deliver the head over the perineum, but failed. After waiting some time to see if nature alone would accomplish anything, and in the meanwhile the young woman becoming more and more exhausted, with no prospect of any favorable change, with the approval and at the request of Dr. Bahrenburg, I proceeded to make the operation of craniotomy, and safely delivered her of a large female child. The mother made a rapid recovery and was well in two weeks.

This case, which I have put down as No. IV, occurred Nov. 1, 1888, and case No. 3 happened Oct. 24, 1888.

To have two such rare cases so near each other was most remarkable, as I had met with no such position in many years. My first case happened some fifteen years ago, when I attended a primipara, who had a lingering labor lasting over three days, as it was an occipito-posterior position, and with the assistance of Dr. Walker in consultation, we succeeded in delivering her with forceps of a dead child. She had a slow convalescence, but recovered, and was delivered by me some fifteen months later of a healthy living boy. Case No. II was a premature child (seven months), and it was born alive, although the occiput was posteriorly situated, and it was so delivered. In this case I attributed the faulty position to a large-sized pelvis, and this was the reason that rotation did not take place, but from the large capacity of the pelvis, the child was born alive. It is a sad report to make of four such cases, all but one fatal to the child; but I regard this peculiar position and failure of normal rotation as a matter of very great importance to the obstetrician, and we should be prepared to cope with such vicious positions when we meet with them in practice. I am quite sure it is a matter that has been very much neglected by obstetrical writers, and, as it occurs so seldom in practice, very little is said about

it. However, in the most recent work upon midwifery, *Am. System of Obs.*, by Hirst, v. i, p. 576, he says :

“If I were asked what one obstetrical difficulty in my experience had caused the most maternal and foetal deaths, what one had caused the most maternal and foetal accidents, not necessarily fatal—accidents, however, often making the rest of life worthless, or still worse than merely a worthless tragedy—I think I would say, occipito-posterior position, where the occiput had rotated into the hollow of the sacrum, and which had been improperly treated.”

From the above it will be seen that such a vicious position of the head is a most formidable matter in obstetrical practice. The best treatment we can recommend, is to make the diagnosis early in the labor, and then try and introduce the whole hand and rotate the occiput forward. To do this successfully, the bag of waters should be preserved as long as possible, and we think it can be done better if the woman is in the knee-elbow position. In some cases of shoulder presentation I have succeeded in rectifying the position by keeping the woman upon her hands and knees, or *reversed*, that is, lying with the limbs up, so that the uterus may stand in a perpendicular position, with its cervix situated upward, and fundus downward. When the occiput lies posteriorly the posterior lip of the uterus is depressed and the anterior lip elevated ; the occiput lying behind tends to depress the posterior lip below the anterior lip, so that the cervix will be found unusually low in the pelvis. As the vertex lies posteriorly in the hollow of the sacrum, the expulsive power of the uterus acts through the spine of the foetus, and the neck is curved so as to make an angle, and thus presents an obstruction, and when it is pushed out of the hollow of the sacrum it has to change direction and take an *up-grade*, when it meets with resistance at the perineum.

Now, remember the whole foetal ellipse is packed into the lower pelvis, and the uterus is empty, although still powerfully contracting, and cannot act upon the foetus. To expel the foetus, with the occiput posteriorly pressing on

the perineum, will require for its delivery that the mother shall herself powerfully bear down, and, by the aid of the forceps, we can elevate the head and produce flexion until the occiput has glided over the perineum; then extension is to be made, so that the *sinciput* may be released from its impacted position under symphysis, when complete delivery may be accomplished. We would, when the head is pressing down upon the perineum, and meets with obstruction there, and is greatly endangering it, have suggested that lateral cuts be made in the perineum, so as to relieve the obstruction, and assist in the delivery of the head; for at this period the distended perineum is a great bar to delivery, and the occiput can glide over it without rupturing it. We have occasionally made the operation of *episiotomy* in cases of normal position, where the perineum was unusually distended, and we were sure that the head could not be expelled without a rupture, and we have found it a most admirable resource. This little operation which has been called "the young practitioner's operation," was first learned in the obstetrical clinic at Vienna, under the direction of Prof. Braun, and to guard against a traumatic rupture of the perineum, it is emphatically an operation, if not an election, one of *necessity*, and in a few cases where we have had occasion to resort to it we have never regretted so doing. The incisions usually heal spontaneously, much better than jagged lacerations made from long pressure of the foetal head.

Finally, I appeal to the members of the Clinical Society, that it seems to me not inopportune to suggest that we have reached that place in our profession where it would seem at least both creditable and advantageous for us to begin to turn our attention to the details of obstetrics, as well as to gynecology.

*Résumé.* I. When the occiput does not rotate normally, and it is driven down into the cavity of the pelvis, it has to travel at least three times as far, as when it is anteriorly situated.

II. In this *vicious* position, the whole body of the child is jammed down into the cavity of the pelvis, and this is necessary before the occiput can escape over the perineum.

III. In this position, the occiput is at first forced a downward grade, into the hollow of the sacrum, and then to further advance, it must take an *up-grade* in order to glide over the perineum.

IV. In posterior rotation, as I have stated, the occiput has to travel at least ten inches before reaching the outlet whereby it can escape into the world and the whole foetal ellipse (which only measures eleven inches) becomes jammed down into the cavity of the pelvis, and then the uterine power for expulsion is lost, although the pains still continue, and exhaust the mother.

V. One of the most frequent accidents of delivery when the occiput rotates posteriorly is if the head is delivered in this position, that the perineum is ruptured.

VI. When such cases occur, and we cannot deliver with the forceps, I would propose that lateral sections of the perineum be made, (episiotomy), and then the delivery can be accomplished. After such a proceeding, I should advise that the lateral cuts be closed at once by catgut sutures. Experience has proved that such wounds made by the knife will heal much easier than jagged wounds made in the central line by long pressure of the head, producing traumatism.

ST. LOUIS, 409 N. Grand Avenue, Beer's Hotel.

II. EPISIOTOMY.—In introducing this topic Dr. Leavitt said: "With regard to episiotomy I take pleasure in submitting an epitome of the views of Professor Phil. Porter, of Pulte, and Professor J. N. Mitchell, of the Hahnemann College, of Philadelphia, which I am enabled to do through recent correspondence. Professor Porter writes me as follows:

DETROIT, Mich., Nov. 26, 1888.

*Prof. S. Leavitt, M. D.,*

DEAR DOCTOR:—Yours here. Yes, I have resorted to episiotomy three times in my practice, and, although there



was no rupture of the perineum I was in doubt whether there would have been had I not employed episiotomy. In one case there followed phlebitis, and later sloughing of the entire labial portion, giving me an ugly wound to treat. The other cases, while they presented no trouble, raised a question of doubt in the minds of the patient and her friends, as to its benefits, etc.

Any surgical operation that necessitates an apology every time it is resorted to, and has associated with it doubt, seldom, if ever, becomes popular; at least I am satisfied, and shall not resort to it again without there are some unusual reasons.

Hastily yours, PHIL. PORTER.

Doctor Mitchell has a more favorable opinion of the operation, as shown by this letter:

PHILADELPHIA, Nov. 25, 1888.

*Prof. S. Leavitt, M. D.,*

DEAR DOCTOR:—In reply to your favor of 20th inst., asking me whether I have ever “resorted to episiotomy with a view to save the perineum,” I have to reply that I have done so but three times. Each time the perineum was put upon a great strain, and yet there was not a sufficient yielding in the vaginal orifice to permit the passage of the head.

In one case the occiput had rotated into the sacrum, but in the other two the occiput was under the arch. In one case the muscles of the perineum were so elastic that the head had passed out of the pelvis almost entirely. In all three cases I saved the perineum by my operation, though in one I had to put a few stitches into the parts that I had cut, as my incisions were increased somewhat. In certain and proper cases I think most favorably of the operation.

Fraternally and truly yours,  
J. NICHOLAS MITCHELL.

We shall never have a better opportunity than the present to elicit the views of this Society on the operation under consideration, and an invitation is extended for a full and free discussion.

DR. LUDLAM said that, while the report had thus far been of great practical interest, he, for one, felt that it was incomplete until Dr. Leavitt had given his own views and

experience upon the two subjects properly before the meeting.

DR. LEAVITT: Rarely have we an opportunity in our Society to discuss so excellent and practical a paper as that submitted by Dr. Comstock this evening; and it gives me great pleasure to offer a few remarks upon it.

There is one point incidently mentioned in the paper upon which I believe our essayist to be slightly in error, and that is his statement that, when the vertex lies at the pelvic outlet in an occipito-posterior position, the uterus, though contracting with energy, is empty, and therefore has no propelling power over the foetal body. To be sure the occiput has to descend a considerable distance, and then, as Dr. Comstock tells us, is under the necessity of traversing an upgrade to reach the location in question; but even after that migration the foetus must still be within the embrace of the womb. This of course, would not be true did not that organ descend considerably and become greatly distended in its lower segment.

Now a word concerning the management of these occipito-posterior positions in their early stages. Some years since Dr. E. W. Sawyer reported to the American Gynecological Association a few cases of occipito-posterior positions, and took occasion to state his conviction that rarely does the head spontaneously rotate so as to bring its occiput at the outlet under the pubic arch. Upon this belief he bases a treatment of these cases consisting in use of the forceps and forcible rotation.

Quite a number of years since Dr. Parry, in a contribution to *American Journal of Obstetrics*, took a similar view of the natural course of occipito-posterior positions, and recommended, as applicable to them with scarcely an exception, introduction of the hand at an early stage and forcible rotation forward of the occiput. Now I believe these methods of treatment are based upon an erroneous view of the course spontaneously taken in most of these unfavorable positions. Altogether I have had a number of cases wherein the occiput, early in labor, was turned back-

ward, and yet in which spontaneous rotation forward of the occiput took place. I say spontaneous, but I ought, perhaps, to qualify with a further statement, that, by manipulation with one or two fingers, and by keeping the head well flexed, I doubtless aided the movement. For this reason I am disinclined to recommend the adoption, in the early stage, of forcible measures to accomplish the desired end. In several instances I have applied the long forceps and enforced rotation. To do this we are under the necessity of making what I term a double application of the instrument; that is to say, we must first apply it with the concavity of its pelvic curve looking toward the forehead, and then, after partial rotation, in order to avoid inverting the instrument, and thereby injuring the soft pelvic tissues, we must remove the blades and exactly reverse their direction in a second application, so as to complete the rotation. This is a delicate operation and one not to be undertaken by every novice, inasmuch as, when unskilfully done, there is great danger of traumatism.

In these cases rotation must not be attempted until the head is bulging the pelvic floor, since at an earlier stage the part has not cleared the superior strait. A double application of the instrument would not be required provided we made use of a strong pair of straight forceps, an instrument by the way, rarely used I believe at the present time.

I ask the indulgence of this Society while I offer a few observations on the operation of *episiotomy*.

I have had occasion to resort to it some five or six times and have never regretted so doing. None of these, however, were such cases as the four reported by Dr. Comstock, and I may add that it has never been my misfortune to encounter any such. You will understand from the report, that Dr. Comstock himself made no incision, but in reflecting upon these cases he has resolved to do so should another such occasion present.

You doubtless observed in the letter from Dr. J. N. Mitchell that he has performed episiotomy in one instance

similar to those reported, and with satisfaction. My cases have all been occipito-anterior positions, if my recollection faithfully serves me, where the vulvar opening was so small, or the head relatively so large, as to threaten inevitable laceration of the perineum. The necessary incisions may be made with scissors and need not be deeper than half an inch. One to four of these should be made on either side of the posterior vaginal commissure. If any stitches are subsequently required they may be made, as suggested by Doctor Comstock, with cat-gut, and we will rarely or never fail to get prompt union. I regret the unfavorable experience of Prof. Phil. Porter, as I have learned to well-regard this operation in suitable cases.

DISCUSSION.—DR. R. LUDLAM must speak, if at all, as an ex-teacher of obstetrics. He had been greatly interested in the essay furnished by his friend, Prof. Comstock, in which he had really cited a remarkable experience. Not only the members of the Clinical Society, but the readers of the *Clinique* also would be profited by this contribution to our literature. Dr. Leavitt's stricture upon the view that, when the child's head is at the perineum in occipito-posterior positions of the vertex, the child itself is always outside of the uterus, is a just one. The idea that spontaneous rotation of the vertex always occurs posteriorly, as held by our good friend Sawyer, is not tenable, and could not have originated with a pupil of my old teacher, Prof. Hodge. It is good practice, but it is not always possible to recognize the drift of things early enough in a vertex case to prevent its rotation into the hollow of the sacrum. Manifestly, the use of any great amount of force to correct a vicious position of the occiput might do a deal of harm by traumatising the soft parts. It is a much safer and better way to suggest and to assist the rotation anteriorly by milder and more persuasive means.

Of episiotomy I am inclined to think more favorably than I did before learning the practical difference between a surgical operation that is made upon a *pregnant* and one

that is made on a *puerperal* woman. In cases of extreme rigidity of the perineal or vulvar tissues, or where these textures are deformed, and in atresia of the vagina; in the narrowness of the pubic arch, making what is called "the male pelvis," and in other deformities of the lower pelvis; and, as Dr. Comstock has suggested, in vicious presentations and positions it may be an available resource. The worst of it is that the warrant for resorting to it is not what it should be, unless we are morally certain that the labor could not be safely finished without it—and such a conclusion is not always possible.

But I apprehend that the combined experience of the obstetrician and the gynecologist might help us to determine when this unusual expedient would be justifiable. We all know that there is a clinical relation between rigidity of the uterine cervix and that of the perineum in labor. Hence the rule, that when the gynecologist finds a decided laceration of the neck of the womb he will almost always find a corresponding rent in the perineum, and *vice versa*. Given a case of labor, in which many hours, or days, have been passed in the active effort of the uterus to force open its own door, and the inelastic ring has finally been torn asunder, and you will almost certainly have a corresponding delay and danger of rupture at the vulvar orifice. If a clean cut will heal more quickly and safely than a ragged rent; and if the chances for saving the child's life, and for helping the poor mother to get through with her suffering are greatly increased thereby, why is not the indication a good and sufficient one?

Of course it should be done with antiseptic precautions, and with the perfect understanding and consent of those who are most interested, else serious trouble might follow. It would not help a young doctor's reputation to do much of this kind of work; and there is always a risk of puerperal mischief. I like Dr. Leavitt's idea of making the incision with the scissors instead of the knife. They were used for the same purpose by Ould, in 1742. If it must be resorted to, my own preference is for Tarnier's incision,

which is made along the raphé of the perineum with a lateral inclination, so as to avoid the recto-vaginal septum, and to prevent its being torn if there should be an additional laceration.

Dr. J. D. CRAIG.—I would endorse Dr. Leavitt's statement that posterior-vertex positions can be remedied without violence. I employ both internal and external manipulation. To prevent accidents, however, I rely more upon preparatory treatment. I believe that for parturition a woman needs a course of physical training as much as an athlete does for a race. Walking is an exercise that I insist upon. To develop the recti muscles I advise rising from the recumbent position without the aid of the hands. Frequent employment of this exercise will strengthen all the abdominal muscles. I also advise the daily use of sweet, or cocoanut oil on the vulva and perineum as a prophylactic measure.

Dr. N. C. KEMP.—I would like to ask Dr. Leavitt how deep he makes these incisions, and if he ever finds it necessary to insert sutures?

Dr. LEAVITT.—Not more than half an inch deep. I prefer to make several incisions rather than a single deep one. I sometimes insert stitches.

Dr. W. S. GEE.—Is it not possible by a moderate use of anæsthetics to remove a part of the resistance so that vicious positions can be more easily modified?

Dr. LEAVITT.—I judge that in the cases reported by Professor Comstock anæsthetics had been used when he afterward found it impossible to move them at all.

I can see no advantage in Tarnier's operation as described by Prof. Ludlam, and in fact regard the necessary length of the incisions as rather objectionable. In the method described by Dr. Comstock, there is no danger of cutting important structures provided the incisions are made midway in the posterior quadrants of the vulvar circle. If deep incisions are made at these points some fibres of the transversus perinei muscle may be cut, but this would do no special harm. Prof. Ludlam gave you a valu-

able clinical hint in his remarks concerning the frequent and nearly uniform, co-existence of cervical and perineal laceration, and you will do well to bear it in mind.

DR. E. S. BAILEY.—I have the highest regard for Prof. Comstock's opinions and practice in obstetrics. I believe that it is possible for the head to be crowded down so far into the hollow of the sacrum as to be beyond the control of the uterus. My experience is that these difficult cases can be helped by the moderate use of anæsthetics; just enough to take off the wire edge of the pain, so that the woman can act more intelligently and so assist the accoucheur. Is it not the usual experience that in these severe and awkward cases the greatest danger to the perineum is from the shoulders rather than the head?

DR. LEAVITT.—There are obstetricians who believe that the shoulder is the more frequent cause of damage to the perineum, but I believe they are mistaken. Certainly my own experience does not accord with theirs.

DR. GEE.—It is in case of primipara that the perineum is usually more or less torn, I would like to ask Dr. Ludlam if the uterine cervix is as frequently torn.

DR. LUDLAM.—Lacerations of the cervix are I believe as frequent in occurrence as those of the perineum, but they more often heal spontaneously.

## Hospital Notes.

### THE CLINIC ON NERVOUS DISEASES.

#### SERVICE OF PROF. FELLOWS.

**FACIAL SPASM.**—*Case 15,258.*—Mrs. S., aged forty-five years, entered the clinic October 22, 1888. The first of the spasmodic action appeared in the muscles about the eye, previous to the birth of her fifth child, six years ago. The spasms became worse after the labor, and then extended so as to involve the entire right side of the face. Another aggravation of this condition took place after the birth of the sixth child, two and a half years ago. She has never suffered from any general convulsions, at child-birth or at other times, and these spasms are strictly localized in the right side of the face. The left eye is reported weak, but the field of vision is good in both eyes. She has a "strange feeling" from the occiput over the top of the head to the forehead. Never much headache. After her confinement there was always great nervous prostration. The face looks care-worn. The twitching is worse at the menstrual period.

This is a typical case of facial spasm of the clonic variety. You will observe nearly all of the muscles of the right side of the face, both about the eye and mouth, are involved. In some cases the spasms are tonic instead of clonic, but the clonic variety greatly predominates in frequency.

It is, perhaps, impossible to assign any exact cause for the spasm in this case; at least there is no cause given which is entirely satisfactory to my mind. If the cortex of the brain in the facial region is the seat of the difficulty, the spasm is the only evidence of it. If the nucleus of the seventh nerve is affected no other symptoms help us locate the origin of the affection there. If any disease produces pressure upon the nerve in its course outward, it at least must have been stationary for years.

There is some foundation that it may have been reflex in its inception, for it began during pregnancy, and was twice increased by confinement; it is also worse during menstruation. This lady does not suffer from any marked uterine symptoms, so far as we can learn from questioning her; in fact, seems to be in pretty good health, except as to the spasms of the face.

The fact of these spasms coming on during pregnancy and being aggravated by menstruation may mean, and in



this case I believe does mean, that the nervous system at such times is more sensitive to all malign influences.

The confinements were probably more than usual shocks to the system, as shown by the greater than usual nervous prostration following them. This would account for the increase of the disease at those times, for it has been observed that other shocks which act generally on the nervous system, and not locally on the facial nerve, may aggravate or cause this disorder. The pregnancy and confinement must, therefore, be considered as only general, and not as special causes which developed such a condition of spasm. There must have been back of all this some specific weakness of this nerve. It will also be seen that any cause which disturbs this patient's nervous equilibrium causes an aggravation of the spasms.

This form of facial spasm does not affect children. They have facial twitchings, as you have seen in one of the little girls coming to the clinic now, but in this case it is only a feature of chorea. Children sometimes have some twitching of certain muscles of the face, as winking rapidly for a number of times in succession, or raising the eyebrows frequently, but in such cases it is more a part of some general nervousness. Sometimes these conditions appear to become a habit, and are at least temporarily under the power of the will, but will-power has no control over this case. These cases in children, although often obstinate, are generally, by proper remedies, including a change of climate or surroundings, curable.

The prognosis in such cases as this depends much upon the specific cause. Where that can be discovered and removed, the spasm will be relieved. This is especially true when the cause is reflex and due to some irritation of the fifth nerve, like carious teeth. Where the cause is some faulty condition of the seventh nerve itself, and that undiscoverable, and where the condition has become fully chronic, as in this case, the prognosis is not very bright. In those cases where the facial spasm depends upon some organic disease of the brain the out-look is bad.

This case was given *tarantula* at first without much good effect. This was followed by *causticum*. This has been followed by some apparent improvement; more days passed with little twitching, and more hours passed without any, but it has always returned. More time will be necessary before the permanent value of the remedy can be told.

## Clinical Reviews.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, Vol. I, No. 1, January, 1889.—This is a new monthly publication by Wm. Wood & Co., of New York, which will furnish a series of practical medical and surgical essays that are inaccessible to the general profession in a readable form and for a very reasonable price. Taking the first issue as a sample we have no hesitation in saying that this is the most creditable and satisfactory scheme yet devised by any of our medical publishers. It contains the remarkable lectures, six in all, upon *The Pedigree of Disease*, by Jonathan Hutchinson, F. R. S., which should be read and thoroughly digested; *The Common Diseases of the Skin*, eight brisk lectures by Robert M. Simon, M. D., Cantab., etc., etc., of the General Hospital, Birmingham, England; and a series of clinical lectures on *The Varieties and the Treatment of Bronchitis*, translated from the French of Dr. Ferrand, Physician to the Lænnec Hospital. In all there are 259 large and well-printed pages such as, if repeated monthly during the year, will be worth many times the price (\$10.00) that is asked for the series.

THE HOMŒOPATHIC THERAPEUTICS OF DIARRHŒA, DYSENTERY, CHOLERA, CHOLERA MORBUS, CHOLERA INFANTUM, AND OTHER LOOSE EVACUATIONS OF THE BOWELS, by JAMES B. BELL, M. D., Third Edition, Philadelphia. F. E. Bœricke, 1888.

It is impossible to estimate the amount of good which this little book has wrought in the last twenty years, and we therefore welcome the new and enlarged edition with unfeigned pleasure. The hearty and wholesome confidence of the author in the yield of this kind of work is encouraging to the last degree. "The more closely one follows the principles discovered by Hahnemann the more priceless appears the legacy which he has left us. We have no occasion to join in the pursuit of our new, but speedily discov-

ered drugs, lauded first as specifics, then thrown over for their failures and harmful effects. We are able at once, by proving and observation, to rightly estimate and use the new as well as the old remedies, and the knowledge thus acquired will be just as valuable centuries hence as now. And so we work on with the solemn joy of those whose work will never cease to bless mankind while there remain any sick to be healed."

PROCEEDINGS OF THE TWENTY-FOURTH ANNUAL SESSION OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF OHIO, HELD AT DELAWARE, May 8 and 9, 1888. The Secretary, Dr. C. E. Walton, will accept our thanks for a copy of this comely volume of more than 200 pages; and the President of the Society, Prof. Schneider, of Cleveland, likewise for his earnest words on behalf of the hackneyed subject of Medical Education. It is unfair and unfortunate that those who are most given to discuss this topic in our yearly gatherings, and in the journals, either have a personal grievance or a grudge against some particular school, (which has perhaps strained a point to help them or their friends into the kingdom), or they take a malicious pleasure in that sort of criticism which "overlays a pithy text with a windy sermon." Now, our friend Schneider is not of the class of whining school-marms who are so anxious to turn State's evidence against the colleges that they resemble the old Egyptians who gambled away the mummies of their fathers. And the consequence is that he has made an earnest and an eloquent appeal in behalf of those of us who, under so many disadvantages, are doing our best to fit and prepare our students for their chosen work.

The clinical reports contained in this volume are clever and practical, but the discussions are open to the improvement that would surely be realized if the members were in the habit of convening more frequently. For the men who speak most to the purpose on bedside topics are the men who meet with their brethren oftener than once a year. The paper by Dr. D. H. Beckwith, on the "Sophistication of Foods" is worthy of his reputation as a sanitarian: the proving of Magnesia Phosphorica, by Doctor H. C. Allen, is excellent and very suggestive; and the report of a case of Vaginal Hysterectomy, by Dr. C. E. Walton, is helpful and worthy of record.

A TREATISE ON THE DISEASES OF WOMEN, FOR THE USE OF STUDENTS AND PRACTITIONERS, by Alexander J. C. Skene, M. D., Professor of gynecology in the Long Island College Hospital, etc., etc., with 251 engravings and 9 chromo-lithographs: New York, D. Appleton & Company, 1888; pp. 966.

Whoever has taken especial pains to collect all the available books upon any single branch of medicine or surgery and afterwards made himself familiar with their contents will have observed that most authors have developed one subject most fully and carefully, and afterward grouped the remaining topics about this one in a more or less indifferent manner. We buy such books and consult them as special aids, and need them all as practical friends in our work. We refer to them just as the obstetrician of thirty years' experience and reading goes to BEDFORD'S OBSTETRICS for his chapters on the use of the forceps, or to Hodge to brush up his obstetrical geometry.

Now this big book is no exception to the rule. It will always be noted and valued because it includes the book by which its author will always be kept in remembrance, *id est* his special treatise on the Diseases of the Urinary Organs in Women. Three hundred pages, or about one-third of its space, are devoted to this single subject.

The next best portion of the volume is that given to plastic operations upon the cervix uteri, the vagina and the perineum. Both the text and the illustrations are excellent, the latter being chiefly original and really admirable. But we are disappointed with the description and advice given concerning some of the major gynecological operations.

What is said in these pages of antiseptics, and especially of the spray, must have been written years ago, and is not now in accord with the experience of the best operators in this or in any other country.

Dr. Skene's repute in plastic operations and his thorough presentation of them in this work causes us to wish that he had more confidence in the curative efficacy of remedies when applied to other classes of cases. For the book is one-sided, and surgical, manual, and not medical, to the last degree. There is some compensation for this, however in the concluding chapter, which is devoted to insanity as it is related to the diseases of women, a subject with which the author is practically very familiar; and also in the discussion of electricity as a therapeutical resource. The volume abounds in well-chosen and carefully reported clinical cases.

## Miscellaneous Items.

Volume X of the CLINIQUE opens herewith. With a new printer, new type, press-work and engraving, and a fresh influx of the old clinical spirit it will, we trust, be more than ever welcome and useful.—The worthy Secretary of the American Institute would notify everybody through us that our National Society will hold its forty-second annual session at Lake Minnetonka, beginning Monday evening, June —, and continuing until Friday night, June —, 1889.—Dr. T. F. H. Spreng, good luck to him, has removed from Buchanan, Mich., to Sioux City, Iowa.—Those who take the *Current* while it serves, will be glad to know that Dr. E. F. Storke, of Milwaukee, is editor thereof.—Whoever would attend the proposed International Homœopathic Congress to be held in Paris in August next, during the Exposition, should address Dr. Marc Jousset, 241 Boulevard Saint-Germain, for particulars.—“Is the American heart wearing out?” is the palpitating title of a pamphlet by our friend Dowling, of New York.—The *Eye as a Factor in Functional Nervous Diseases*, by Dr. F. Park Lewis, of Buffalo; *The Treatment of Fever by the Ice-coil*, by Dr. Geo. N. Kreider, of Springfield, Ill.; and *the Doses of Drugs and Medicines*, by Dr. J. W. Hayward, of Liverpool, are recent practical publications.—The *Clinical Record* is a new journal by Mr. W. A. Chatterton, of this city.—For the fifth time Dr. Belle L. Reynolds has been reappointed Physician in charge of the Chicago Home for the Friendless.—The Commencement exercises closing the twenty-ninth annual session of the Hahnemann Medical College and Hospital, will be held on Thursday, Feb. 21, 1889.

SPECIAL NOTICE.—The next annual meeting of the Alumni Association of the “old Hahnemann” will occur on Wednesday, Feb. 20, at 8 P. M., at the Sherman House, Chicago. An address will be delivered by the president, Dr. M. H. Parmelee, of Toledo, O. The Alumni will attend the regular Commencement exercises the next day, and participate in the banquet in the evening. All who can be present are requested to address the Secretary, Dr. H. V. Halbert, 2400 Prairie Avenue, Chicago.

# THE CLINIQUE.

Vol. X.]

CHICAGO, FEBRUARY 15, 1889.

[No. 2.

## Original Lectures.

### *HYPERTROPHY OF THE TURBINATED BODIES.*

A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN HOSPITAL OF CHICAGO, DECEMBER 22, 1888, BY W. A. DUNN, M.D., CLINICAL INSTRUCTOR IN DISEASES OF THE THROAT AND NOSE.

I will show you to-day two marked examples of the different forms of the somewhat common disease, Hypertrophy of the Turbinated Bodies. The first case is one of the so-called Anterior Hypertrophy, as it is found over the anterior portion of the turbinated bones; while the second case is one of Posterior Hypertrophy, being located at that part of the turbinated bodies.

These two varieties differ very much in their form, but not in their pathological conditions.

In the first case there is difficulty in breathing through the nose at all times, and when the patient has contracted a slight cold there is complete stenosis. As you remember this boy also suffered from adenoid growths of the nasopharynx, for which we operated some time ago with most excellent results, and were it not for this hypertrophy, he would be very comfortable.

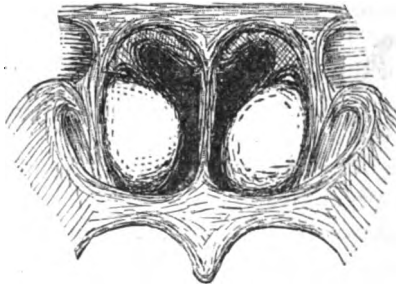
On account of this complication, it is impossible to say how long this lesion has existed, but I am led to believe that it is not of very long standing, as the tissue is not very dense, nor is the growth very large.

There is some muco-purulent secretion, and at times during acute attacks a free mucous discharge. He does

not suffer from headache, and his general health is very good.

By anterior rhinoscopy we find the anterior turbinated bodies enlarged, with obstruction of the inferior openings. The mucous membrane presents a reddened, velvety appearance, and the hypertrophic tissue is elastic when pressure is made with a probe. When a four per cent solution of cocaine is applied the swelling is not much decreased, but the redness disappears.

In the second case, by anterior inspection you find the nares quite normal in size and color, but by posterior rhinoscopy you observe two large, smooth, round tumors almost filling the posterior nasal space as high as the upper surface of the middle turbinated body. These tumors appear purple in color, and are not very dense. On the application of cocaine the growth shrinks somewhat and loses its purple color, showing, therefore, the part taken by the venous sinuses.



My friend, Dr. H. N. Lyon, has made a very accurate drawing of this case by which you can see the large size of the growths, and the uniformity of each, as you will usually observe in this form of disease a marked similarity of the two sides, and seldom will you find one side alone affected.

There is a commencing hypertrophy on both sides of the septum.

In order to understand this condition you must remember the histological formation and the pathological changes that take place. As I have told you the turbinated bodies

are those portions of the nasal tissue covering the turbinated bones, and they are composed largely of erectile tissue, the so-called "corpora cavernosa" of Bigelow, which lies between the periosteum and the mucous membrane, the venous sinuses of which render it capable of sudden engorgement and of as rapid depletion. This tissue is covered by the mucous membrane with its glandular elements and epithelial covering.

Now in simple chronic coryza you have an increase and thickening of the epithelial layer, with a certain amount of congestion of the submucous tissue; but if from long continued, chronic or often-repeated acute attacks of coryza, there is induration and thickening of the mucous and submucous tissues, we have that form of disease known as "hypertrophy of the turbinated bodies." There is an increase in all the normal elements of the mucous membranes on account of which new vessels are formed. In the corpora cavernosa the walls of the veins are indurated and thickened thereby preventing due collapse and adding much to the hypertrophic condition.

In this manner the body may be increased to several times the normal thickness, and completely close its corresponding meatus. The hypertrophy is not usually regular in its growth, as in some localities it increases more rapidly than in others, so you will find that after applying cocaine some points are thicker and much more dense than others. These hypertrophies are usually found on the free borders of the inferior and middle turbinated bodies, as in these locations the cavernous bodies are much thicker, but the septum also may be affected. If the disease attacks the anterior portion of the bodies it is called *anterior* hypertrophy, in contra-distinction to *posterior* hypertrophy, which is found at the posterior extremity, at which location they are often found so large as to cause a complete stenosis, as in the case of this young woman. Usually the hypertrophic change is very slow in its progress, and it often requires several years before a simple chronic rhinitis has taken on the hypertrophic form.



*Symptoms.*—As you readily understand, the most usual symptom is that of nasal stenosis, which is aggravated from time to time by an acute attack of coryza, by the inhalation of dust or irritating particles, by the too frequent or the too forcible use of the nasal douche, and sometimes, indeed, by simply inclining the head from side to side, which will cause a congestion and closure of the corresponding nasal cavity when it is affected by hypertrophy. When you remember that the venous walls have lost their contractility because of long-standing congestion and thickening, it is easy to see how this frequent occlusion may occur. If the stenosis be great there will be the so-called “nasal twang” or a muffled tone, with inability to correctly sound the nasal consonants. The nasal passages, you know, are the sounding boards, as it were, of the voice, and if they are occluded it is much as if you remove the sounding-post in a violin; you have a tone but not all the modulations that can be obtained from a perfect instrument.

This condition is often the result of the inflammation and swelling of the soft palate, which accompanies this trouble. The patient being unable to breathe through the nose, soon acquires the stupid expression of the mouth-breather, and is the unhappy victim of all the results of this most unnatural method of taking the breath. As a result of this unnatural mode of breathing, by which the air, loaded with irritating particles, and not warmed and moistened by its usual entrance through the nasal passages, we often find such persons suffering from pharyngitis and laryngitis. The inflammatory condition may implicate the lachrymal canals and the conjunctiva, causing redness and lachrymation.

If the inflammation extends into the Eustachian tube, you will find the hearing lessened, and many times quite lost. There is oftentimes very severe headache, especially if the frontal sinus be involved in the inflammation.

The sense of smell may be impaired if the upper portion of the nasal cavity is involved, or if the lower portions be so much increased that the air can not enter the olfactory portion. That of taste is often modified, in those cases in

which the sense of olfaction is not perfect. There is usually an increase of nasal secretion. If the swelling is so great that the discharge does not find a ready outlet through the anterior portion, you will detect it in the sinuosities of the cavities where it forms greenish-brown masses or clinkers, owing to the evaporation of the fluid portions, which, becoming decomposed, cause a very fetid odor of the breath, that in scrofulous persons is very disagreeable. Sometimes quantities of a viscid mucus accumulate in the posterior nasal region, and the patient resorts to violent efforts to clear the nose by forcibly drawing the air through the nose in such a manner as to bring the discharge with it into the throat, whence it is hawked out.

This violent hawking and scraping soon causes so much irritation in the post-nasal space that the glands are stimulated to over-action and inflammation follows.

The mucous membrane of the soft palate and the uvula involved in the same irritation becomes relaxed, and has much to do with the change of voice of which I have spoken. This viscid mucus coming into contact with the pharyngeal wall only adds its pernicious influence to the mouth-breathing to cause a persistent pharyngitis, as well as laryngitis. The discharge running down the pharyngeal wall comes easily into the posterior portion of the larynx between the arytenoids, causing a thickening of the mucous membrane, and as I have said, this is one of the so-called "cough spots." Hence, such patients are often troubled by a more or less constant cough, and often imagine themselves victims of tuberculosis, and indeed you can easily see how this condition may be the exciting cause in one markedly predisposed to that much dreaded disorder.

This inter-arytenoidian inflammation and thickening, together with the general congestion of the larynx, often causes asthmatic attacks, especially from exertion. You will often see a reflex asthma that results from the pressure of the turbinated bodies.

I must add a few words in regard to the posterior hypertrophy, cases of which you will often meet when you

come into practice. This condition usually attacks the lower turbinated bodies of which there are two varieties, the *white* and the *purple*. In the white form you observe an irregular tumor filling one or both choanae with an irregular surface very much resembling a raspberry. In this form the thickening is confined to the mucous and submucous tissue, but it does not seriously involve the erectile tissue. This form may be found also on the middle turbinated bodies, and the posterior end of the septum. The purple form, which is much less frequently observed, is confined almost exclusively to the lower turbinated bodies, and is composed largely of venous sinuses, with their thickened walls. Such cases are often subject to hæmorrhages on slight irritation, and especially so from removal of the growth.

*Prognosis.*—So far as concerns the local disease, there are no dangerous conditions in those persons in whom there is not already a faulty diathesis; and since the introduction of surgical treatment as an aid to the properly selected remedy, the results obtained are usually very satisfactory. Sometimes after the disease has advanced far enough to occlude one or both the nasal passages, it remains stationary until middle life, at which time the tissue is absorbed, and the patient is quite free from further trouble. This condition cannot occur, however, if the bones have also become enlarged. Beside the unpleasant symptoms resulting from the local stenosis, one of the most disagreeable of which is “nightmare,” or disturbed sleep, is the very great danger to the hearing.

In examining these cases you will often observe that the patient is quite deaf in one ear while the other will be very good, or both may be diseased. The deafness often comes on so gradually that the patient is unaware that any change has taken place until the trouble is far advanced.

Anosmia and perversion of taste are common results on account of destruction of the olfactory cells, or from occlusion of the nasal cavities.

Pharyngitis and laryngitis, because of the oral breathing and the contact of the viscid discharge from the nasal cav-

ities, are frequent results; and asthma and emphysema may result from the nasal occlusion if long continued.

*Treatment.*—In order to successfully treat this condition it is very important to differentiate simple chronic from hypertrophic rhinitis, the tests of which I have already given you, but which I will repeat that you shall have a clear understanding of the condition before you.

On applying a four per cent solution of cocaine, if the membrane over the turbinated bodies becomes much reduced in size, and the surface is smooth, you have simple chronic rhinitis; but if the surface is irregular, and nodular, and is not much reduced, you have hypertrophic rhinitis. Hypertrophic tissue is elastic, but in simple coryza the tissue is inelastic when a sound is applied.

As you know, this disease is the result of a catarrhal inflammation, hence the prophylaxis consists in the judicious treatment of the primary trouble in accordance with the treatment that I gave you when speaking of chronic coryza. You will have many cases in which the tissue elements that characterize this affection are in the stage of transformation, and by proper medicinal treatment, together with local pressure by means of bougies, continued for some time, you will be able to resolve away the new formed tissue and restore the membrane to its normal condition. If, however, the tissue change has become firmly organized, clinical experience shows that remedies have but little effect on the new formation, and it is only by surgical means that can we hope to obtain permanent results.

Besides the remedial treatment that I have given you under the head of coryza, you will be able to obtain much relief from local applications by the aid of sprays or douches, the last of which should only be used as a post-nasal application in those cases in which the discharge is very tenacious, or forms into crusts which can not be removed by more gentle means. As a rule, you will succeed best with a fine spray that is supplied with a straight and a curved point. I prefer one with a single bulb that is capa-

ble of making a continuous spray. Such an instrument is found in the Magic Atomizer No. 5. A serious objection to this atomizer, however, is that the point may become detached in the throat and be swallowed by the patient. I have ordered some made with a screw-point, which will obviate this risk. The most pleasant solution to be used as a spray is Listerine, one or two drachms to the ounce of water. This solution thoroughly disinfects the parts and also aids in bringing away any secretion that may lie in the nasal cavities.

The hydrastis, two drachms to the ounce of water, or glycerine in the same proportion will be of service to keep the parts free from secretion, especially in cases where there is but slight decomposition of the retained discharge.

When this disease is fully established and the hypertrophy is of such size as to obstruct the proper nasal respiration it is best to destroy the redundant tissue with the electro-cautery point, or some caustic acid, as the nitric, chromic or glacial acetic. The most efficient method, as I shall show you in the first case to-day, is by the electro-cautery point, which has a projection on the side of the fine aluminum wire which, when heated to a cherry heat is drawn across the thickened tissue in such a manner that the knife-like wire cuts through the membrane and the cavernous body. There is no active inflammatory condition, and in the cicatrization that follows the tissue is bound down to such an extent that the meatus is very much enlarged. Care must be observed not to touch the septum, and especially the border of the nasal opening with the hot point. There are many instruments made to protect the septum, but all that is usually necessary is to apply a little ointment on the septum, and use proper care. The best protection to the external border is a hard rubber nasal speculum, after the style of Dr. Harrison Allen.

After the operation, I usually apply calendula cerate to aid the healing process and to protect the parts from irritating particles, and if the patient is much exposed to dust, or if the weather is very cold, I plug the one side with ab-

sorbent-wool or cotton for a few days. No violent inflammation follows, and in a week or ten days the thickening is seen to have disappeared to such an extent that the meatus admits a very free passage of air.

Should you not have access to a battery, you may destroy the tissue by applying pure nitric acid. I wrap a small film of absorbent-cotton around this little instrument, which I have had made as a general nasal applicator, being of silver and made very flat and pliable. This having been dipped into the acid and the superfluous fluid absorbed that it may not do harm, is introduced along the turbinated body in such a manner that only a line of the tissue is destroyed by it. There is usually more inflammation after this than after the electro-cautery, but the results are very good. The chromic acid crystals may be fused onto the end of a sound and drawn across the body, by which the tissue will be destroyed. It is not the intention to destroy much surface but to extend deep enough to bind the tissue to the periosteum, as well as to cause contraction of the remaining tissue.

In all operations of this nature it is essential to thoroughly anæsthetize the parts with a five or ten per cent solution of cocaine, applied on cotton. But it is not best to use such a strong solution in the nose with the spray, as it is both dangerous and disagreeable to the patient. For the second case, which is the purple form of posterior hypertrophy, we shall use the post-nasal electro-cautery snare, of which I shall speak at the next lecture, when we shall operate on both of these patients.

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## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

JANUARY MEETING, 1889.

The regular monthly meeting of this Society was held in Parlor 44, Grand Pacific Hotel, at 8:30 P. M., January 26, 1889. In the absence of the proper officers Dr. W. H. Burt was called to the chair, and Dr. Otto Poppe was appointed Secretary *pro tempore*. The attendance of physicians and students was unusually large. After some preliminary business the Society heard and enjoyed

### THE REPORT OF THE BUREAU OF CLINICAL MEDICINE.

DR. W. J. HAWKES, CHAIRMAN.

I. DYSPEPSIA.—BY W. J. HAWKES, M. D.—The word *dyspepsia* or *indigestion* is, according to modern writers, an insufficient definition for this disorder. Dr. Julius Glax has recently classified the different kinds of indigestion as follows :

In group *I* we have the *motor neuroses*. (*a*) The irritative forms, which are (1) peristaltic and antiperistaltic mobility of the stomach ; (2) morbid eructations, belching, etc. ; (3) nervous vomiting ; cramps of the stomach, cardia and pylorus. (4) The depressing forms at or near the stomach ; insufficiency of cardiac regurgitation (merycism), insufficiency of the pylorus.

Group *II*. *Sensory neuroses*. (1) Cardialgia, central, reflex ; (2) changes in the physiological sensations of hunger and satiety-anorexia, nervosa or gastric hysteria ; (3) pyrexia or perverted sensations of hunger.

Group *III*. *The secretion neuroses*. (1) Irritative forms, hyperacidity, nervous gastroxyusis ; (2) depressing forms, deficient secretion.

All this refinement of definition and classification aids us but little, however, in performing the physician's duties of preventing disease and curing the sick. It is not my object to enter into a history of all the varied causes of dyspepsia. Like all other chronic diseases it is a result of two causes—(1) the constitutional predisposing cause, which is usually an inheritance from the sins of the fathers; and (2) the exciting cause, which is external and accidental.

The first maxim in medicine is to remove the cause. The chief function of medicine is to attack the former, and it is the function of hygiene and sanitation to remove or prevent the latter.

Indiscretions in diet in all their varied forms I hold to be the principal causes of dyspepsia, and chief among these is that of rapid eating. In 1881 I presented an article to this Society, elaborating this same view.\*

This article was regarded by some at the time as laying too much stress upon the importance of the saliva as a factor in digestion. Within the past year the results of careful experiments made with a view of ascertaining the value of the saliva as a factor in the problem of digestion, measures were taken to divert the saliva from its natural course. The results proved beyond a doubt that the saliva was not only essential as a lubricant and as a beginner of digestion in the mouth, but that its action was continued in the stomach, and that the gastric follicles secreted their product much more freely when the saliva was allowed to enter the stomach than when it was prevented. Digestion seemed to almost cease; the activity of the gastric follicles was diminished three-fourths, and digestion proceeded with extreme slowness and incompleteness in the same stomach which, after the introduction of the normal amount of saliva, in the natural manner, performed its functions perfectly. Drs. Stutzer and Isbert have recently made extensive and careful experiments in order to ascertain the action of diastase, peptic and pancreatic ferments upon digestible carbohydrates, exclusive of fats. The object of these experi-

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\* THE CLINIQUE, Vol. II, 1881, page 129.



ments was to see by what series of fermentative actions the greatest amount of carbo-hydrates could be digestible. The substances used for the experiment were hay, meal and bread. A certain amount of these substances was mixed with solutions of ptyalin, pepsin, pancreatic ferments and diastase. They thus discovered the interesting fact that by treating the above disorder first with ptyalin solutions, then with pepsin solutions, and finally with pancreatic solutions, the largest amount of digestive action could be obtained. It was also found that ptyalin, contrary to the usual belief, acted to a slight extent upon albuminous food.

The general results of these experiments go to show that the saliva has an important role in digestion, and that when it is not secreted properly, diastase can only in a measure supply its place. In view of the results of these scientific experiments, it is safe to say that the importance given in my article before this society in 1881 to the saliva as a promoter of digestion was not too great.

The manner in which our fast-living Americans deprive themselves to a large extent of this important secretion is by rapid eating, and the greatest aid in this reprehensible habit is the act of drinking liquids during the meal. This point I emphasized then, and I increase the emphasis now. As nature prepared man's food, mastication was absolutely necessary to deglutition. Art in cooking has in a great measure obviated this necessity. Food is ground and cooked and prepared in such a way as to require for deglutition comparatively little mastication. Such a necessity as does yet exist for mastication is still further decreased by this reprehensible dyspepsia-producing habit of drinking liquids with the meal. Even with all the aid given by modern cookery, our food would yet require considerable mastication and consequent flow of saliva, were it not for this almost national habit, which is the cause of the stomach being overtaxed and handicapped in various ways. The food is thrown into it too rapidly, imperfectly masticated and not insalivated, so that the gradual intermingling of the gastric juice with its mass is in a measure prevented. The stomach

has to a certain extent to furnish saliva, do the duty of teeth, and labors under the additional disadvantage of an insufficient amount of gastric juice. And, further, this rapid eating is a cause of too much eating. Hunger being a systemic call of the nervous system upon the stomach for nutriment to repair waste, and half an hour, at least, being required after the food has entered the stomach before a considerable portion of it has been rendered fit to replace broken down tissue, the natural sensation of satiety has not been experienced until the stomach has been overfilled. Twenty minutes would probably be a fair average of the length of time consumed by the American business man in taking a meal; consequently in the cure of dyspepsia it is of the first importance to insist upon the patient's not drinking any liquid whatever during the meal. This will necessitate mastication, and insure insalivation. Permit him to drink as much of proper liquid as he may desire either before or after meals. It is also well to insist upon his taking few different kinds of food at the same time. A mixture of three or four or more substances, each in itself wholesome and digestible, increases the difficulty of digestion. They may be, so to speak, incompatibles; one may require two hours for digestion, another three, another four, and so on. I always insist in stubborn cases of dyspepsia that only one or, at most, two articles shall be taken at one meal.

I contend that every case of functional dyspepsia, that is to say, dyspepsia not complicated with or caused by organic change, can be cured by a persistent and intelligent enforcement of these hygienic rules, and the selection of the indicated homeopathic remedy.

Clear hot water is the best of all drinks for a dyspeptic, or any other stomach, but especially for the dyspeptic. It is, if such a thing can be, a stimulant without reaction. Too much of it cannot be taken; no injury can result from its use. The mistake made by so many is of thinking that the hotter it can be swallowed the better the effect. The stomach is less sensitive to heat than the lips or mouth, and may tolerate with but little discomfort a temperature

so high as to parboil its mucous membrane. The water must not be so hot as to be uncomfortable to the lips and tongue. Oftentimes the dyspeptic, soon after eating a reasonable meal, complains of a gone feeling in the stomach. He at once interprets this as meaning a lack of food, and weakness resulting therefrom, and immediately proceeds to supply what he deems the want. The fact is this so-called "gone, empty feeling" is more often a dyspeptic craving, and is a direct result of an accumulation of gas in the stomach rather than of a vacuum there. The proper course to pursue in such cases is to drink a cup of water as hot as can comfortably and safely be taken. In a little while, if it is dyspepsia and gas that causes the sensation, the gas will be liberated and the sensation disappear, and no hunger will be experienced. If, on the other hand, it was real hunger, the drinking of the hot water will not dissipate it; and the hunger will remain after the water has been drunk. This is a simple, wholesome, and accurate test of this question.

*Medicinal Remedies.* Among the homeopathic remedies useful in the treatment of dyspepsia, the most prominent are in my experience, in the order named—*nux vomica*, *lycopodium*, *arsenicum*, *pulsatilla*, *mercurius*, *antimonium crudum*, *ipecac.*

*Nux vomica.* The most characteristic symptoms of this drug (all these remedies have many symptoms in common) are a feeling of weight and distress in the stomach an hour or so after eating, with sour belching. The patient is dull, sleepy, and irritable. The sick headache that results will be of a dull, heavy character, with a sense of enlargement of the head. If the bowels of the patient are constipated, as is often the case, he will experience a frequent ineffectual desire for stool. He will almost invariably awake from sleep between two and three o'clock in the morning and lie awake restless or half asleep until his usual time of rising, then he will be dull, sleepy, and indisposed to rise.

*Lycopodium* is characterized by certain liver and kidney symptoms accompanying the dyspepsia, as well as many of

the usual symptoms peculiar to this disease. The patient's period of aggravation will be from four to eight o'clock in the afternoon; he almost invariably feels worse between these hours; he complains of suddenly becoming tired about that time, and when asked about that symptom he usually tries to explain it by saying he was getting naturally tired towards evening. He often has pain in the small of his back—renal region—which is aggravated if the urine be retained longer than usual, and is relieved after passage of urine. This patient will go to table with a fair appetite probably, and think he is going to eat a reasonable meal, but a mouthful or two satisfies him; it gives him a sense of satiety and fullness as though he could not eat another mouthful. If there is much pain accompanying his dyspepsia, it will be between the stomach and heart, causing a good deal of anxiety and apprehension, His complexion will be sallow, and his bowels constipated.

*Arsenicum.* The arsenicum patient complains that the character of his distress in the stomach is burning; that his stomach cannot tolerate cold water, which he greatly craves; he can take it only in the smallest quantities. If taken in considerable quantity it causes heaviness, coldness, and general discomfort in that organ. He rarely suffers from constipation, but more frequently has diarrhoea of a watery consistency and burning of the parts, and smelling very badly. He will also be extremely restless at night. Just for an hour or two after midnight his period of aggravation ends where that of *nux* begins—between 2 and 3 A. M. He has an unaccountable feeling of prostration; face pale and haggard. Arsenicum will especially be indicated if the attack has been caused by drinking much ice water, or eating ice-cream or ices.

*Pulsatilla.* The characteristic features of this remedy in dyspepsia are a disgust for fat food; anything greasy or fat disagrees with and is disagreeable to the patient. Her mouth tastes very badly in the morning; no appetite for breakfast. The *nux* patient is irritable; the *pulsatilla* patient is despondent and low spirited; feels very much better in the

open air in all respects. If the head is aching and the patient is feeling sick while in a warm room, especially if the atmosphere is close or overheated, going into the open air relieves all the symptoms, removes the headache and makes the patient feel better in every way. It will be especially adapted to those suffering from amenorrhœa and similar conditions.

*Mercurius* is characterized chiefly by an excessive flow of saliva; sensitiveness of the gums and teeth; apthæ; tendency to dysentery; uncomfortable sweat at night, etc.

*Antimonium crudum* is characterized by an irritability of temper. The patient is cross and peevish; he has a heavy, thick, white coating on the tongue; nausea, and when diarrhœa exists the stools are partially hard and partially watery.

*Ipecac.* The chief characteristic of this remedy is nausea; a pinching pain about the navel; grayish-green diarrhœa; sick headache.

Any other remedy in the materia medica may, however, be the one indicated and curative in any given case of dyspepsia.

II DYSPEPSIA.—By H. P. HOLMES, M. D., Sycamore, Ill.—The word dyspepsia, according to its etymology, means difficult or bad digestion; but to-day in its meaning it is made to cover a multitude of physical sins. In its general use it is a misnomer, and there is, perhaps, not another word in the nosological field so often misused or misunderstood. As a rule this trouble is a resultant and not the cause of the array of symptoms so frequently placed to its credit. Generally accredited to a disturbance of the central organ of the system, we are prone to overlook the fact that the producing influence may arise from a more or less remote organ, or oftener still from an individual habit over which the digestive apparatus has no control.

In order to understand fully the proper treatment of this affection it is necessary to understand all the features which go to make up its history. And this is where the greatest error in treatment is frequently made. It is easy enough

to diagnose dyspepsia in a way that is suitable to the patient, and easier still to formulate a course of treatment which sounds well to the ear. But the result of such treatment is often not the desired thing to either patient or physician.

The point I wish to make in this paper is, that dyspepsia is more often a trouble arising from a set of causes over which the digestive apparatus has no control, and consequently a set of causes against which the treatment must be directed if we ever hope to achieve any permanent or beneficial result. To direct our treatment against the then existing symptoms is, to begin with, the wrong end of the trouble and to have a backward trend all the way through.

Dyspepsia, in the sense to which I refer, is essentially an American disease. There is, perhaps, no people as a nation, who so completely sacrifice the welfare of their digestive systems in favor of their business interests as do we Americans. It seems the necessity of the times, and the man or woman who, in business life, will not allow the pressure of business affairs to interfere with nature's demands upon the powers of digestion is a rarity. All the sins of the body, outside of those which go to make up a first-class case of dyspepsia, are not so great as those entering into the causes of indigestion. Our people not only fail to follow out the essential rules of how and what to eat, but their principal failure in this respect is in not properly preparing themselves for this most necessary act of digestion. We come tired and worn to our meals, little thinking that our stomachs are weary and exhausted as well as the rest of the body. We bolt our food, we force it down without the necessary precaution of first masticating it, and then flush it down the œsophagus with all sorts of drinks because kind nature revolts at alimentia in such condition being forced upon her.

To know how to live well it is absolutely necessary to know how to dine well. And to dine well it is first necessary to know how to come to the table with a digestive apparatus rested and suitably prepared for the duties which

it must perform. Did we but take the same care of our own digestions as we do those of our valuable stock, we would more of us reach the biblical age of three score-and-ten. A man will not feed his horse when it has been over-driven until it has had the proper time for rest and recuperation. But there are few who ever think of the necessity of using the human animal in the same reasonable manner.

There are few men who will consent to separate their business interests from their bodily affairs long enough to eat in a suitable manner. I have seen business men eat in a way that plainly showed the necessity for three hands, and was an evident reflection upon the wisdom of the Creator for such short-sightedness. One hand was constantly shoveling in the wonderful variety of indigestible viands, the other kept busy in drenching the food with alternations of black coffee, ice water and the contents of a labeled bottle, while there was a constant by-play upon his watch with first one hand and then the other. Just think of it, a business man in the midst of health, wealth and prosperity, without time enough to eat !

After the vital error has been made by the possessor of this much abused stomach, the next greatest error is often made in the method of treatment. Too frequently is the patient told that his liver is out of order, or that his stomach does not do its work properly or, perchance, the bowels are sluggish or the portal system obstructed. Go on with your diagnosis and then reason out the prescription. Give your digests, give your liver regulators, move the bowels and stir up the portal system. What is the trouble? The trouble is that the treatment like the nature of the supposed malady has been directed against the result and not the cause of the affection. It has never occurred to the patient that he has not learned how to dine well, and it may not occur to the physician to instruct him. But here lies the essence of the treatment and it must not be overlooked.

When the causes of the disease are once fully appreciated, and the methods which led to its production are corrected, then is the time and not before, to direct suitable

remedial treatment towards removing the injury which has been sustained. And here is where one of the greatest benefits is derived from Homœopathy. In our school it is not necessary to treat conditions of disease, so to speak. Dyspepsia, like all other diseases, can best be treated by directing our remedies against the symptoms of the individual. There are, perhaps, few cases in practice where it is so essential to take down the case thoroughly according to the Hahnemannian instructions. It is not necessary to resort to the many preparations of pepsin or pancreatine as a digest. It is not necessary to take a tonic before meals and a digest after. It is not necessary to confine the patient to a particular diet with relation to the constituent elements of the food supplied. Only put the patient upon reasonable alimentia and, if he does his part of the work in a suitable manner, we can expect from our remedies all and more than can be expected from the above customary forms of treatment. But so long as the patient transgresses all the rules of digestive health, so long as he uses the nervous system to the total disregard of the functions of digestion, and so long as he calls to the brain the force that is necessary for perfect digestive action, just so long will his case resist the best laid plans of treatment and thorough, capable, medicinal intervention fail of its intended result.

*Treatment.*—The first thing in the treatment of a case of dyspepsia is to see that the patient conforms to those reasonable laws of nature which are known to be of so much importance in the correction of this trouble. Our patient should, if necessary, be taught to eat. Not only this but he should be made to realize the importance of coming to the table with his digestive apparatus suitably prepared for the labor it must undergo. In this respect one of the most vital elements is a rested condition in which the stomach has gained the necessary strength. A tired, exhausted person should never sit down to a hearty meal. Should this condition at certain times seem unavoidable, then the meal should be prefaced with soup or other light, nutritious food and, if necessary, no heavy



or hearty diet allowed. With a well-rested system at meal-time many of the errors of digestion will be avoided.

When we reach the point of remedial treatment it is of the greatest importance to take the case well. And here we are cautioned by Hahnemann in the *Organon*, paragraph 91: "When the disease is an inveterate one, or if the patient has persisted in the use of medicine up to this time, he may omit the same entirely, or something of an unmedical kind may be given him, while the rigorous examination of the case is postponed until the unadulterated, permanent symptoms of the chronic disorder can be ascertained in their purity, and a true picture of the disease obtained." We are directed in the next paragraph what course to pursue in case the disease be too urgent to allow of waiting; but in most of these cases we will really gain time by waiting until we find the immediate effects of old drugging have passed off, and until we feel confident we have the true picture of the disease. Dyspepsia is a disease which needs careful examination in making up the case, and careful homœopathic treatment will produce the most satisfactory results.

DISCUSSION.—DR. GEE.—The papers presented are practical and deal fairly with a common condition, but one that is difficult to control. When we recall the haste manifested to eat a little breakfast, hurry it down with coffee, run for a train, enter upon the excitement of business, take a lunch, if at all at any time from 12 to 3 P. M., with insufficient time to eat it, and after the business of the day run for a train, reach home exhausted and eat a hearty meal *without previous rest*, it is not surprising that indigestion follows.

In fact it is strange that *any* stomach can tolerate such treatment. Add to this combination improperly prepared food, and food taken in unnatural quantities. The patients suffering from this functional derangement belong to three classes: (1) Those depending on mental worry and nervous strain. (2) Those of sedentary habits who need exercise; and (3) Babies who are fed improperly.

As a type of the first, one case may be given.

*Case I.* Mr. W. aged 41, fell in the station while waiting for a train, but recovered consciousness shortly after and walked with but little assistance to my office, one block away. On again sitting down he was nauseated and soon vomited an unsavory mixture of coffee and partially digested food.

He seemed to awake anew after vomiting and was quite surprised to find where he was, not being conscious of anything that had transpired from the time of the fall to the emptying of his stomach. He then stated that two days previously he hurried for a train, rode some miles from the city to close a real estate deal, ate some sandwiches, drunk two cups of "railroad coffee," and hurried to the train and reached home much fatigued. He was late in waking in the morning, did not have time for breakfast, but drunk two cups of coffee and hastened to the station. The train was late and many gentlemen were in the crowded room, and the foul air and smoke were sickening. He probably fainted. It took him some time to convince his many interested friends that he was not an epileptic. A rest from business and some treatment restored him to fair health.

Some of these patients must have complete divorcement from business, as a trip to Europe, or go out of business for a year or a fixed time.

*Bryonia*, *Lycopodium* and *Nux vomica* are the remedies most frequently indicated.

*Case II.*—Miss O—æ. 23, seamstress, tall and slender, has been subject to "dyspepsia" for several years. She has occasional acute or sub-acute attacks, when she suffers very much. She has been treated by several physicians and tried "everything she heard of" to get relief. She had the usual symptoms, and in addition spoke particularly of the *burning in the stomach after eating*, and *eructations of an offensive character*. She received *Capsicum* with prompt relief. In fact it developed new symptoms of the remedy, such as tickling and itching of the end of the nose. She needed no more medicine.

Care must be taken in giving specific directions to this class of patients as to exercise, sleep, eating and rest.

Of the third class is

*Case III.*—Baby, aged eighteen months, was strong and healthy and the parents left it in the care of some friends while they took a two month's trip down the St. Lawrence

river. The family physician was requested to call frequently and look after its health during their absence. His visitations began soon after their departure and were continued with marked regularity until the parents returned. The little one became emaciated, sleepless, peevish, unable to take food and gave them great alarm. They were dissatisfied and because of the almost continual loss of sleep of both the parents and the child other help was sought.

The symptoms presented about in this way: The child was thin and very much wasted, had a diarrhoea with stools of undigested food, no appetite, or a fitful one, was sleepless, constantly changing its position, could get no rest, kept twirling and rolling its hands and arms, and moving its whole body as if in constant distress. I gave *Cina*, one dose at the time, and the child slept most of the first night and recovered without any other medicine.

The failure of the first treatment was attributed to bad feeding, and dosing with various foods and decoctions supposed to "help digestion, etc."

A dose of the proper remedy to set the nervous system right again, and proper care were sufficient to cause a speedy recovery.

The "aids" of various kinds are not such in reality. There may be times when adjuvants are necessary to tide over some emergency, but these are rare. To induce an appetite when the stomach is not in condition to digest the food is harmful and not beneficial. It is *natural* to eat, and for Nature to indicate the kind and quantity of food that is needed, and it is very unnatural to disregard these facts. If everything that prevents recovery is removed, the proper remedy will correct the difficulty.

DR. SKILES. I think it important to remember that we are not always able to control dyspepsia by the use of remedies alone. If we look for local complications in the case of men and women we shall find that the cause is not always of the kind that has been noted in the report. Indeed it is often organic and remote, and the gastric symptoms are reflex.

DR. W. H. BURT was pleased in general with the papers presented, but he would note one or two exceptions. In the great majority of cases of this disease mental worry is

*the* cause. Some obscure cases depend upon diabetes, and a saccharine or starchy diet is the worst of all for dyspeptics. He thought that Dr. Hawkes was too much carried away with the injurious effect of drinking at meals, for drinking stimulates the gastric secretion. Adjuvants, when properly chosen, were his great forte in treating the different phases of indigestion, and he did not know how he could practice without them.

DR. C. S. MACK spoke of the importance of a proper preparation of the food as prophylactic of dyspepsia.

DR. H. P. HOLMES almost never uses adjuvants, the chief reason for which is that in the majority of cases that come to him they have been through and become disgusted with that kind of work already. He expressed himself as being seldom disappointed in the action of properly chosen remedies.

DR. SKILES believed that simple brain-work does not interfere with digestion, but that, in case the emotions are involved the stomach will be upset.

DR. BURT advised lying upon the right side after taking a meal as an aid to digestion in some cases.

DR. HAWKES, in closing the discussion, said: In the paper presented by me, I endeavored to make it plain that it was not the liquid *per se* that was objected to. I distinctly said that as much as was desired might be taken before and after the meal. But Dr. Burt's remark that "what little was taken with the meal couldn't do much harm," makes me fear that I did not express my meaning so clearly after all. I will hope, however, that the Doctor's inattention is partly to blame, and that others present have not made the same mistake.

In regard to the question of the advisability of sleeping soon after having eaten a hearty meal, it seems to me there is a general misapprehension. The opinion of a majority is that it is unwholesome so to do. Circumstances and common sense must decide the question. With a hearty individual it is natural, and therefore healthful to sleep after eating a *proper meal in a proper manner*.

This is proved by the natural habits of all animals. With them, the greater the meal the longer and more profound the sleep; and sleep under such conditions need not be disturbed by the night-mare. If, however, as is the rule with civilized humanity as at present ordered, the individual has already eaten too much for the day, or has eaten improper food in an improper manner, or has eaten while exhausted, or while mentally or emotionally disturbed, digestion will be labored, retarded, and sleep-disturbing. But it is not the sleep that disturbs digestion; it is the bad digestion that disturbs the sleep.

It will not do for a Board of Trade man, for example, whose business and most exciting hours are about noon, to eat his heartiest meal in the middle of the day. One should eat most heartily, other things being equal, when he has least else to do; for then there will be the least distraction of nervous energy from the digestive apparatus.

A word in regard to what I call a "dyspeptic gnawing;" and which is often caused by distension of the dyspeptic stomach by gas. This feeling is nearly always regarded by the patient as hunger and weakness from lack of food, and his remedy is more food—adding fuel to the flames. The way to manage that is this: Give the patient orders to take at such times a cup of hot water. If the distress was caused by the influences indicated above, the hot water will dispel them without further tiring the stomach. If it was real hunger that caused the symptoms, they will soon reappear; and food will then be the proper remedy.

VOLUNTEER PAPERS.—THE CAUSATIVE RELATION BETWEEN THE DISEASES OF WOMEN AND NEUROSES. TRANSLATED BY W. F. ROBINSON, M. D.\*—If we find a pathological condition of the sexual organs, and at the same time a neurosis, both occurring in the same individual, the important question immediately arises as to the relation existing between

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\*Extracted from Prof. Alfred Hegar's Work on *The Relation of Sexual Diseases to Nervous Troubles, and Castration in Neuroses.*

the two. Is or is not the neurosis caused by the sexual trouble? It is not necessary to prove that the affection of the generative organs is the exclusive cause of the neurosis. In the production of separate symptoms, or sets of symptoms, many different factors of various degrees of importance may concur. On the other hand it must be proved that the sexual trouble is an integral factor in the production of the neurosis, and that without the genital affection it would not have occurred.

The simultaneous presence of anatomical changes in the sexual organs and a neurosis in itself proves nothing. Such changes do not necessarily produce any nervous symptoms, or indeed any symptoms whatever. Pathological change and symptoms belong together. If any one had marked anatomical change of any organ, or part of the body, and no unpleasant symptoms or danger resulted, he would certainly take very little account of it.

Absence of the uterus may be combined with active ovulation, and yet no unpleasant symptoms be produced. Placenta prævia may run its course without hemorrhage. Patients may have an extreme retroversion of the uterus without suffering the least inconvenience therefrom.

I have been consulted by young women on account of sterility, and found, on examination, pyosalpinx of both tubes, with extensive exudation in the neighborhood, of gonorrhœal origin, and all this without any inconvenience to the patients. Great importance has been attached, in this connection, to the seat of the neurosis, and especially symptoms in the lumbar region of the cord, are referred by the people as well as by the doctors, to the genital tract. Women suffering in this way generally apply to a gynecologist, and this is perhaps the reason that these symptoms, forming as they do a sharply defined clinical picture, are so often slighted in works on nervous diseases, and are very likely to be found hidden away in the chapters on neurasthenia or spinal irritation. This general opinion about the origin of these symptoms is not without a certain justification. The sexual organs seem to have their own nervous system, which is to a great extent independent. We know from Goltz that in the lumbar region of the spinal cord there exists a sort of center or point of union into which run the nerves that come from the genital tract, as well as those from the bladder and the rectum, all of which organs stand in close relation to each other. All influences which affect the sexual apparatus, or go out from it, must

either be produced by direct contact, or through the blood, or else they traverse the lumbar region of the cord. Röhrling found that certain agents, as some chemical substances and mechanical and electrical irritants, would induce contractions of the uterus; other agents, on the contrary, could not produce their effect except through the spinal cord. To the latter belong exactly those agents which particularly interest us, as Ergot, Strychnine, Calabar, Sabina, Chloralhydrate, Chloroform, etc. Asphyctic blood and anæmic conditions act also only through their influence on the cord. Oser and Schlesinger have already demonstrated the participation of the centers in the production of dyspnœa. Moreover morphinism seems to exercise its powerful influence upon the sexual organs and their functions exclusively through the cord. This has not been experimentally proved.

The probability, however, is very strong, and is still further increased by certain phenomena which indicate the participation of the inferior section of the spinal cord in morphine poisoning, *viz.*: pain or feeling of great weariness in the small of the back, conditions of semi-paralysis in the bladder and the lower extremities, even ataxic conditions in the latter. Goltz has also demonstrated the dependence of vascular fullness in the abdominal and pelvic vessels upon the lumbar region of the cord.

Another circumstance which tends to prove the close connection of the female sexual organs and the spinal cord is that symptoms referable to this latter region are much more frequent and intense in women than in men. In women these nervous centres are affected by the sexual systems in an entirely different manner than occurs in the case of men. Naturally it is not the diseases of the sexual organs alone which affect the cord, for it may become diseased independently. Many women have a natural weakness of this portion of the nervous system which makes itself known by a certain insufficiency of the sphincter vesicæ, and even of the sphincter ani; a tendency to cold feet, and inability to stand or to walk for any length of time. This portion of the cord may be influenced in many different ways from the upper portions of the cord, and indirectly from the peripheral nerves in connection with them. Directly from the peripheral nerves of the lower extremities, the bladder and rectum, and from the bony and fleshy cavities. Disturbances of the circulation, anæmia and hyperæmia, as well as altered conditions of the blood,

are all important factors in this connection. In persons who have suffered severe losses of blood there is often a feeling of weariness in the small of the back, or painful sensations here and in the iliac regions. "Tension neuroses" are met with in very lax abdominal walls, or movable kidney, as well as in cases of prolapsed or retroverted uterus. Severe pains in the loins may result from forced bending of the spinal column. Pain in the back and iliac regions, and still more extensive disturbances of sensibility are often produced by continued over-strain of the dorsal flexors by paralysis of the abdominal muscles, or by an abdominal tumor which would displace the center of gravity forward. It is a very important fact that such influences, not emanating from the generative organs, which affect the cord or pass through it are able to change the functions, and after long duration even the structure of the sexual system. Physiological experiments have indicated to us how these results may be brought about by showing that the lumbar region of the cord contains the vaso-motor centre for the pelvic organs. Thus various medicines, asphyctic blood and anæmia, cause contractions of the uterus through this division of the cord.

This peculiar action is well shown in the effect which emotional disturbances, such as anger, fright and anxiety have upon the menstrual flow, sometimes causing the courses to stop suddenly and then again bringing them on before the time. Equally well known is the fact that wetting the feet in cold water may produce sudden cessation in the menses. Careful clinical observations show very plainly that disturbances of the menstrual function, amenorrhœa, dysmenorrhœa, etc., owe their origin to nervous influences. Symptoms referable to the lumbar region of the cord may occur and no sexual trouble be present.

We have given our attention especially to this point, and for some time past every woman coming to the clinic and complaining of these symptoms has been thoroughly examined under an anæsthetic. In about one-fifteenth of the cases the sexual organs were found free from disease. Moreover, it is not seldom to find considerable sexual trouble, and at the same time complete absence of all neurotic symptoms. When the two are present together, as is usually the case, the relation generally is that the sexual trouble is the primary affection, or the cause, and the neurosis the secondary one, or the effect.

However, both are often co-effects of some agent which



acts simultaneously upon the nervous system and the genital apparatus.

Nevertheless, the presence of lumbar symptoms has a certain value as an indication of the origin of nervous troubles. In neuroses of distant parts of the body there is not seldom to be noticed a severe pain, or an ascending aura in the branches of the plexus lumbalis and sacralis which precedes the attacks. There are also simple painful sensations running from the pelvis to the hypochondria, the breasts and the shoulders, which are often noticed without the occurrence of a regular attack.

Of more importance are those affections in which the nervous trouble gradually extends, step by step, from the genital organs to other parts of the body. Such a process I have often seen in contractive parametritis.

Thus, in one case, there occurred first spinal symptoms alone, then hyperæsthesia of the vulva, pain in the left iliac region, drawing and tearing in the left thigh, strangury and tenesmus of the sphincter ani; then a left-sided intercostal neuralgia, mastodynia and contractures in the flexors of the left arm. In a later stage there was an extension to the right side, and general convulsive attacks.

In this case the symptoms were for a long time confined to the left side of the body, and the left uterine appendages were more seriously affected than the right.

As to neuroses in distant parts of the body, it is an important indication concerning their origin when they alternate, as is sometimes the case, with neurotic symptoms which can be referred with certainty to the generative organs.

The sexual apparatus stands in much closer relation with certain regions of the nervous system than with others, and simple irritations of a physiological nature traverse these nervous channels much easier. The close connection of the sexual system with the stomach, throat, breasts and thyroid glands has already been dwelt upon by the earlier authors. The trigeminus also is often affected.

Great weight has also been laid upon the relation as regards time between the neurosis and certain phases of sexual life. The neurosis begins with the development of puberty or during the menopause. It appears only during menstruation, in the middle of the interval, or during pregnancy.

The coincidence of the neurosis with menstruation has certainly a great clinical significance, and still it is over-

estimated. This coincidence has been held to be a proof of the origin of the neurosis when no anatomical changes of the sexual organs were to be found and only functional disturbances were present. Even this has been sometimes considered unnecessary, and the ætiological relation has been judged as proven when the menstruation was entirely normal. This idea has been carried so far that even castration has been performed on these slender indications. This comes from not regarding the fact that in such cases the function of the sexual apparatus is simply the exciting cause whose place as such may easily be supplied by another.

One should not by any means be contented to have found that the sexual system has supplied an ætiological factor, but we should determine the share which it has had in the production of the neurosis. This can be done by determining the other causes of the neurosis, or by carefully seeking out the separate factors having their origin in the anatomical and functional changes of the sexual system.

The extent and intensity of the pathological change does not by any means need to be proportional to the intensity of the neurosis. It is a peculiar opinion of Spencer Wells when he declares that affections of the ovaries are seldom the cause of neuroses because he has seldom seen them in cases of large ovarian cysts, and because when they were present they were not removed by the operation. It is a well-known fact that extensive affections, as for example a large carcinoma, often produce no nervous symptoms whatever, while on the other hand they may be caused by a small scar or by slight changes in position.

The fact of the matter is that nervous phenomena do not allow themselves to be measured with a yard-stick. In large tumors of the ovaries it is easy to understand why neuroses are not apt to be produced.

Large tumors are generally found completely within the abdominal cavity, so that all pressure upon the easily affected sacral plexus is wanting. The pedicle is completely formed so that no tension is produced. Large tumors, filling the cavity in which they lie, can not change their position to any extent, so that little or no stretching or straining is produced. In the case of small tumors it is entirely different. Lying in the abdominal cavity and very movable they produce nervous symptoms by tension of the pedicle similar to a floating kidney. In the pelvic cavity they easily give rise to "pressure-neurosis."

The tendency to the production of neuroses often stands in inverse ratio to the extent of the affection, and the same may also be true concerning their intensity.

If the true glandular tissue of the ovary is completely destroyed, we may expect that many of the secondary symptoms will disappear. The production, and on the other hand the inhibition of a nervous attack by agents, generally mechanical, acting on the sexual organs, is looked upon as proof positive of the origin of the neurosis in these organs. I simply call to mind in this connection the development of epileptiform attacks by moderate pressure on the ovaries and the checking of convulsions by strong compression of these organs, and I will cite a most interesting case: A young woman who was not in the least inclined to be nervous, had on the right side an ovarian cyst of the size of one's fist, with a very long pedicle, and which was extremely movable. The patient suffered daily with neuralgia, extending from the small of the back and the right iliac region toward the shoulder and thigh, probably owing to stretching of the pedicle. It was principally on this account that she submitted to an operation. For the first nine days everything went well, fever and pain being absent.

On the tenth, however, she complained to me that her old trouble had come back, the same as before; that the operation had done no good, etc.

The neuralgic attacks appeared in the days following just as they had before. I examined the incision and found a small abscess the size of a walnut, which had formed from one of the needle punctures. When this was opened the pains disappeared, and did not return. This case explains very well the general law, that a train of symptoms which are the result of a cause, located in one portion of the body, may be produced by some other cause lying in a distant portion of the system. This is especially true when the trouble is of long standing. This explains the fact, that the cause of a neurosis may be removed and the trouble still remain uncured, the ætiological factor having been replaced by some other. And this fact also explains the so-called stationary condition of a neurosis.

One can readily understand that in the nerves in which these phenomena are located certain changes probably occur, and these changes make it possible for some new exciting cause to take the place of the original one.

Any one who has had severe toothache knows that after a time every irritation, and every movement, causes an

increase of the pain. In the employment of massage it is seen that painful sensations are sometimes produced in portions of the body which are not touched in the manipulation. Thus, one of my patients complained to me that massage of the lower extremities produced pain in the hypogastric region. In persons of strongly-developed sexual passion voluptuous sensations are sometimes produced by irritations whose quality and point of application would not lead us to expect such a result.

Caution is, therefore, necessary in the employment of massage, especially in women.

Similar observations may also be made in the physical sphere. If a certain train of thought has become fixed in the mind, all other ideas seem to start this train of ideas, or at least are referred to it.

Even ideas which might be expected to change completely the current of one's thoughts, set the old treadmill again in motion. It is for this reason that a person of advanced age is not in a position to accept new ideas and theories, and is, therefore, apt to be an obstructionist in science. This is a physiological condition in old age, but it may also be met with as a pathological process in earlier years.

The production of a neurosis by mechanical action upon the generative organs stands in contrast to their suppression in the same manner.

That such a suppression can occur, and from points other than that of their origin, is sufficiently proved. Burning the lobe of the ear for sciatica is based on this fact; and irritation of the lower turbinated bone of the nose, in migraine and other neuroses might well be expected to produce good results. Unfortunately the exciting action is met with much oftener than the inhibitory, and this is why persons suffering from neuralgia always seek for the greatest possible quiet and retirement.

Greatly to be regretted is our ignorance of the conditions under which excitation and inhibition are produced.

The artificial excitation, or inhibition of a nervous attack through mechanical action upon some part of the sexual apparatus, has therefore only a modified value, as a proof of the origin of the trouble.

Just as a neurosis, caused originally by some irritation having its seat in the sexual organs, may be produced by another irritation, so may an exciting cause emanating from these organs call forth a neurotic attack whose original cause lay in some other part of the body.

The same is also true of the inhibitory process. Nevertheless these facts have a certain value, which value is increased when it can be shown that a neurosis may be suppressed by inhibitory action coming from the sexual organs and from them alone. The production of attacks of pain in ovarian neuralgia by pressure upon the ovaries must be explained in this way. In such a case there might be changes in the centres in some of the nervous tracts outside of the ovaries, and it is necessary, therefore, to be on one's guard against being deceived. Sometimes the dependence of the neurosis upon sexual disease may be proved after the manner of an experiment.

In flexions and dislocations of the uterus it is sometimes possible by restoring the normal position to remove the neurotic symptoms immediately, and prevent their return. If the organ is allowed to return to its malposition, then the neurosis likewise reappears. Thus obstinate emesis and paresis of the lower extremities will sometimes immediately vanish, when a retroverted uterus is returned to its normal position and held there by a pessary. If the dislocation is allowed to return the phenomena reappear.

I once had a most remarkable case of unbearable, continuous, spasmodic cough, which had lasted for years and threatened to wear out the strength of the patient. The cause was a sharp anteflexion of the uterus, combined with structural changes in the uterine wall. The cough ceased as soon as the normal form of the organ was restored by the application of an intra-uterine pessary. Unfortunately the patient was not able to wear the instrument for any length of time. After exhausting in vain every possible method, I was finally induced to perform the operation of supra-vaginal hysterectomy, removing the ovaries also at the same time. It is now eight years since the operation, and the patient remains completely cured.

It is very important, in the demonstration of the causal relation, to discover just where and in what way the neurosis began. On account of the peculiar formation of the sexual nervous system, and more particularly the female nervous system, the trouble develops on and on, from the original starting point, and reflex effects soon come in to render the condition more complicated. As a general rule the origin in the sexual organs may be referred back to quite simple conditions. The first onslaught on the nerves generally occurs through pressure or stretching, which, however, it must be acknowledged, may be combined in

many ways, and which can not be always or clearly explained. Moreover, exposure of the terminal filaments by means of ulcerations, erosions and catarrh, must also be considered in this connection.

Pressure may be induced in two ways; A swollen or dislocated organ, an exudation, or a tumor presses upon the neighboring nerves and the whole plexus. Pressure neuroses of this sort are extremely common, and it is unnecessary to cite examples. The compression also occurs very often in the tissues themselves, as in the case of inflammatory nodules, hyperplasia of the connective tissue, and particularly in processes of a scirrhotic nature. These attack principally the connective tissue of the ligaments and organs, and are a most important source of neurotic symptoms.

The process may extend to the true stroma of the ovary and the intra-muscular tissue of the uterus, or it may start primarily in these structures.

The contracting stroma of the ovary interferes with the enlargement of the follicles and produces degeneration and abnormal tension in them, whereby the direct compression of the terminal filaments by the connective tissue is still further increased.

The best type of the tension neurosis is represented by proplapsus and retroversion of the uterus. One can easily observe the transition from simple tension-pains to the complex of spinal symptoms, and finally manifestations in more distant parts. Even general neuroses and mental troubles sometimes result from these causes. Less known are those neuroses, more particularly severe neuralgias, resulting from tension of the pedicles of small tumors. I have often observed this in cases where small ovarian tumors have rolled over the broad ligament, thus stretching the pedicle.

The mobility of the tumor can do much toward exaggerating the trouble.

The larger the space that a tumor has in an abdomen with flaccid walls, the oftener will the relaxation and tension of the pedicle occur. With insufficiency of the abdominal walls it is not always easy to say just what part is at fault, for the ligaments of the other organs, such as the intestines and kidneys, are also liable to tension.

Combinations of pressure and tension are sometimes met with.

In inflammatory conditions of the uterine ligaments the tension-pain, in addition to reflex symptoms, is often felt, in

the upright position, in walking and when the abdominal compressors are brought into play. The value of a supporting pessary in such cases is very highly spoken of.

In the case of scars on the cervix and in the vagina we we may have both pressure and tension. In cases of extreme flexion of the uterus we have tension of the wall opposite the point of flexion.

In cases of endometritis the tension caused by the collection of the secretion in the uterine cavity plays an important part. Contractions of the womb are thereby produced, which, owing to the swelling of the cervical mucous membrane, often fail of their object.

These contractions lead to compression of the nerves, which are often imbedded in abnormally altered tissues.

Moreover the trouble is often complicated with perimetritis, and then we may have tension of the adhesions.

When the uterus or the bladder are imbedded in a contracted exudation the elasticity of these parts is interfered with; and moderate effusions give rise to painful contractions and tension upon these rigid tissues.

[*To be Continued.*]

A CASE OF EXTREME PENDULOSITY OF THE ABDOMEN AT TERM.—BY DR. C. M. BABCOCK, OF COLUMBUS, WIS.—I was called Wednesday afternoon to see Mrs. W—, living six miles from the city; found a short, stout German woman aet. 37, in the initiatory stage of her tenth labor. The membranes had ruptured at 3 P. M. At 7 P. M. I made an examination and found no child presenting; introduced at first one finger, then two, then as the vagina was capacious and my hand small, my entire hand and wrist; still no child could be felt and there was little or no resistance to upward pressure. I felt for the mouth of the womb, but found lying parallel to, and directly against the urethra, an opening feeling precisely like a dilated urethra, into which I with some difficulty introduced two fingers. It was as though I had inserted the fingers into a tube of about the same diameter throughout, for after I had thrust in my fingers their entire length, I found no more room within than at the entrance to this purse-like canal. The woman was at full term, had suffered with regular labor pains for at least eight hours, and with slight preparatory pains for nearly twenty-four hours. It may seem ridiculous, but I actually wondered for a moment, if I had

not run my fingers into an enlarged and abnormally dilated urethra; but a little search showed the urethra *in situ* and normal. Another little fact helped out some, which was that when a pain would come, a little water would be expelled through this tube. During all this time the woman was lying on her left side with her back toward me, and had refused to turn on her back to better suit my convenience in the examination, saying it hurt her so to turn. I had now decided that the tube into which I had introduced my fingers, was the cervix uteri, but why the uterus was empty, at least in its lower portion I could not understand. I thought of extra-uterine pregnancy, but here was the woman at full term, without trouble during the nine month's gestation; here was the fact of the rupture of the membranes with an external and proper discharge of the amniotic fluid, and also the repeated lesser discharge at each pain which were sometimes five and sometimes ten minutes apart. Where was the fœtus? Passing my hand over the abdomen I found it to reach to her knees; by further touch during a pain I found the head to press upward toward the ensiform cartilage. In short the extreme distension and flaccidity of the abdominal walls had permitted this tenth child to sink down lower and lower until the breach was nearly to the mother's very short knees, and the head lifted clear out of the pelvis and pointing directly upward instead of toward the outlet of the parturient canal.

The entire lower, or pelvic, portion of the womb was empty; the fœtus was hanging down between the mother's knees. What was to be done? I tried to raise the breech and depress the head, to coax it into the kindly embrace of the superior strait, but it was above such things; so I took a broad band and put it under the lowest portion of the hanging abdomen and around her waist, and from then until morning I tightened it from time to time, at the same time depressing the head, lifting up, manually, the pendant belly, and resorting to various expedients and manipulations. Friday at 7 a. m. I made a thorough examination, found the woman weak and pretty well exhausted—the pains having kept up nearly all the night, the uterus the same as before. No fœtus touchable, although my fingers easily swept the promontory of the sacrum. Still, the breech was higher by eight or ten inches, and the head lower by several inches.

I resolved to persevere, and so giving brandy and hot milk every two hours as food and stimulant, and pulsatilla



internally, I kept up the manipulations. At noon I had the satisfaction to hear my patient cry out in especial distress saying that "something had slipped" within her. An examination showed the head presenting at the brim, and at 7 o'clock that evening the babe was born alive. The long time from noon to 7 P. M. I thought quite necessary to dilate the lower portions of the parturient canal, which had no preparatory dilatation and therefore yielded but slowly to the advancing head. The presentation was the first of the vertex. She made a perfect recovery without any "puerperal mischief."

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## Hospital Notes.

### THE CLINIC ON THE MEDICAL DISEASES OF WOMEN.

SERVICE OF PROF. E. S. BAILEY.

CHRONIC CYSTITIS.—*Case 20302.*—Mrs.——, aged forty-three years, entered the clinic October 5, 1888. She is the mother of twelve children, and has had six miscarriages. She complains of vesical symptoms as follows: Frequent urination, worse in the afternoon and at night. The urine is voided in very small quantities, often drop by drop. Micturition is attended with a fine, stinging pain; sometimes the urine seems hot or scalding, or burning. Frequent and uncontrolable urging with tenesmus vesicæ, which sometimes extends to the rectum. She is worse from walking or standing; finds but little relief in sitting or even from lying down, and is miserable all the time. She also notices that if she has a pain in the groin, or in the region of the kidney, or a colicky pain in the abdomen, that she must instantly allow the urine to pass. She describes the urine as jelly-like, turbid; sometimes shreds are noticed and sometimes a pus-like deposit; again, for days at a time, the water seems normal. Constipation annoys her greatly. The appetite is variable, with a dislike for fluids. Thinks she eats enough, but has little or no craving or relish for food.

The mental symptoms are those of anxiety about herself, restlessness, with confusion and forgetfulness. Her general strength is excellent. Her walk is stooping, her facial expression a constant index of suffering.

The physical examination puts us in possession of these facts: the bladder is in a prolapsed condition, the cystocele being very marked; urethritis exists; there is rectocele and a prolapsed uterus. The cervix uteri is but slightly lacerated and a typical cystic cervicitis is noted. The vaginal walls are very much relaxed. The perineum is but slightly ruptured. There is some abdominal tenderness on pressure. The uterus measures three inches in depth. The menstrual periods are normal. She has been cured of hemorrhoids.

She received *Cantharis* 3 every two hours, and for a local dressing a vaginal plug made of elastic antiseptic-wool, three inches or more in length and large enough to require crowding into the vaginal canal. This support held the uterus, the bladder, and rectal walls in place.

The cysts upon the cervix uteri were incised by a bistoury, a white, jelly-like exudate being obtained. The plug, or tampon, was worn for twenty-four hours and replaced with a new one three times a week.

December 7. The patient's report is that she has improved very much under the treatment. At this time she was told of the radical cure by surgical methods. She declined any such measures, saying: "If I can only have the little pills to take and the bladder fixed up with the cotton, I can now keep myself very comfortable."

January 12, 1889. The patient presented herself at my sub-clinic. The urethritis aggravates her much more than the bladder. Local examination finds the elasticity and tonicity of the vaginal walls much better, although they are still relaxed. The cervicitis is cured. She believes herself improving constantly.

Having examined this patient in the presence of several sub-classes I have called their attention to the following interesting facts: She married when twenty years of age, and is now forty-three, (she appears like one of sixty years,) and her youngest child is five years old. Four miscarriages were at the eighth month and two were at the third month of gestation. She nursed twelve children through infancy, and was pregnant altogether over twelve years of her married life. Poverty and hard work has been her lot; she knows little of luxury and none too much of kindness. Her labors were often long and tedious, her care during the lying-in indifferent or *nil*, and yet her history is that "She is as strong to-day as she was when she was twenty, and does the work for her large family." There is no sub-involution, but a very slight laceration of the perineum and cervix, and if cured of her bladder trouble she would be exceptionally a well woman.

January 25. In the presence of sub-clinic class number four, she reported: The bladder symptoms are so much improved that she has been able to go without urinating for a

period of six hours without inconvenience. The troublesome burning on voiding the urine has gone; the local examination revealed the fact that the cystocele was hardly to be found. The rectocele was not marked and the uterus was quite in place. The urethritis had also disappeared. The only remedy she has taken during the time she has been attending the clinic is given in this report. Prior to her coming here she had been heroically dosed with very large quantities of quinine and iron.

INTESTINAL CATARRH, A SEQUEL OF TYPHOID FEVER.—*Case 20172.*—Mrs. S., admitted Aug. 22, aged twenty-seven years, mother of three children, the youngest being nine months old; weaned her child two months ago. She has not been well for the past two years. At the birth of second child had a difficult labor and has not been well since, although she has improved since the third child was born. She complains of a sharp cutting pain in the left ovarian region, which sometimes extends to the umbilicus; cramp-like pains in the small intestines, coming on suddenly; rumbling of gas, with a frequent urging to stool. The stomach has often a "gone" feeling, with more or less of sharp pains darting through it. These attacks come on at night, sometimes awakening her out of sleep. The bowels are loose, with frequent watery alvine discharges, mixed with a copious blood-streaked mucus. Often times only mucus passes during defecation. The menstrual symptoms are: Menses are regular, but the flow is dark in color, often offensive and clotted, with clutching, constricting pains in the uterine and ovarian regions. The pain on the first day of the flow is sometimes so severe as to cause her to faint. During the menstrual period she is very irritable, is cross and sometimes designedly ugly. Her head aches, the pain beginning at the base of the brain runs up to the vertex and often it feels as if a heavy weight was pressing upon her brain. Often this pain subsides; she is gloomy, regrets her acts of the day previous, cries, and sometimes suicidal thoughts possess her mind. She shrinks from going out when she is likely to meet her friends, and has frequent sighing respiration. Her sleep is fitful, her husband often telling her how she sighed and cried in her sleep.

Local examination disclosed a granular form of cervicitis, tenderness of parametritis; no sub-involution, but

the uterus is slightly prolapsed. There is also an incomplete rectal fistula. *Ignatia* 30, a dose four times a day. A cotton tampon wet with *Hydrastus Canadensis* was placed against the cervix-uteri, and the rectum was to be treated daily with a hot water douche. She was also advised to take a sitz-bath daily.

The patient was requested to report to Prof. Ludlam's surgical clinic for the radical cure of the fistula. The operation (Sept. 27) was a complete success.

Dec. 28 she reported herself as much improved in every way except the catarrhal condition of the bowels. The painful menstrual symptoms had disappeared and so had the rectal. After taking the case anew I was led to believe that the pains in the abdomen and pelvis were dependent upon the sequela of an attack of typhoid fever, which she had before her second child was born. This new fact in the history of her case led me to prescribe *Hydrastus Canadensis* 2, ten drops in a teaspoonful of water, a dose to be taken every three hours.

Two weeks later she reported that she was improving in every way and desired more of "the last medicine."

SYPHILITIC CHANCRE OF THE CERVIX AND VAGINA.—*Case* 20318.—Mrs. B., aged 40 years, has been a mother, the youngest child is four years of age.

The full history of the case was not obtained, as the patient was referred to this sub-clinic, January 7, for the examination, she belonging to Prof. Hoyne's Clinic.

It rarely happens in this clinic to find so marked a case of the syphilitic chancre. The patient says that she has a bad disease, but she does not know just how long ago it was acquired. She has had some of these chancres for weeks, and there are scars where some are now disappearing.

Whenever we observe a round or oval ulcer, as if it were sharply carved out, with the edges abrupt and thickened, and extending deeply into the skin, the uneven floor of the ulcer being covered with a dark-green or yellow, dirty color; with a gangrenous patch of tissue at the base and often bathed with an offensive, watery fluid, such an ulcer is undoubtedly a syphilitic one. I believe it also true that the different tissues of the body are equally susceptible to syphilitic infection, the sole condition being that the virus

shall be brought into a sufficiently direct communication with the blood vessels and lymphatics. The parts ordinarily exposed are the cutaneous surfaces and the mucous membranes, and as the majority of the cases are venereal in their origin the majority of chancres occur upon the genitals.

According to statistics furnished by Fournier,\* the female genitals are liable to syphilitic chancre in the following order. The labia majora, the labia minora, the fourchette, the uterine neck, the region of the clitoris, the vestibule of the vagina, the meatus urinarius, the upper commissure of the vagina, and the vagina.

The members of this sub-clinic class No. 1, saw with me the location of the above-described ulcers and in the following location; one on either side of the meatus urinarius, in the vestibule, the size of a split pea; one just within the meatus urinarius, upon the labia majora and minora; two upon the cervix uteri, one of them upon the anterior lip, and one that was very nearly hidden in the angle of a deep cervical laceration on the left side of the cervical canal, and extending into the canal. This last ulcer was oval in shape and deep, its edges indurated, and the base of a very dark green color. It was exquisitely tender to the touch by the sound and could not have been seen had not the blades of the speculum widely separated the torn cervix.

Where the blades of the bivalve speculum permitted the lateral vaginal walls to be put upon a moderate tension and to be thoroughly exposed, there was upon the left lateral side of the vagina a long, deep syphilitic ulcer. There was also an induration with a typical chancre encroaching upon the meatus urinarius, which was interfering with the passage of the urine. There were several chancres about the anus which had nearly healed.

While the authors upon this subject speak of these localities as being rarely infected, a very extensive search into the literature of the syphilitic chancre in the female sexual organs discloses very few statistics. The chancre

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\* Reference Hand Book of the Medical Sciences, Vol. II, p. 67.

upon the vaginal wall receives no mention save by Bronson, and its occurrence is extremely rare.

Concerning the chancre, concealed within the urethra, in the male, out of seventeen hundred and seventy-three cases examined, seventeen cases were found. Ricord makes this the basis of his claim, that there are a certain number of cases of syphilis where the primary lesion was not, or could not be discovered.

I can find no reference to a *concealed chancre within the torn surface of the cervix uteri* as we noted in this case. Without the supporting evidence of the other chancres we should have hesitated in pronouncing the sentence of syphilis upon our patient. That this might have been a source of systemic syphilitic infection there can be no reasonable doubt. Had there been but this one chancre and its presence not noticed, or had its specific character not been recognized, it would have been possible for this patient to have always wondered how she could possibly have contracted syphilis.

Winckel, \* in making up the differential diagnosis in carcinoma of the uterus, remarks: "(4) Partially gangrenous syphilitic ulcerations of the vaginal portion of the womb are often very difficult to differentiate from carcinoma."

It is therefore among the possibilities that syphilitic uteri are operated upon for cancer, and in the non-healing process the failure to get good results is charged to the want of skill of the operator.

At the first visit of the patient, not knowing what her treatment had been, I advised *Thuja*, 3 five-drop doses, every two hours and requested that all infected parts be anointed with thuja cerate. One week afterward, Jan. 11th, the patient reported: "Better in very many ways." The same treatment was advised to be continued.

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\* Diseases of Women, page 372.

## Clinical Reviews.

LECONS DE CLINIQUE MEDICALE FAITES A L'HOSPITAL DE LA PITIE (1886-87), par S. JACCOUD, Professor, etc., Paris, 1888.— In the whole clinical output of Paris for the last few years, nothing is more valuable than the annual volume of object-lessons by Jaccoud, who, since the death of Trousseau, is perhaps its most eminent medical teacher. For his clinics in la Pitié abound in the most recent knowledge, and are brimful of interest to the practitioner. This fourth volume of the series is smaller than its predecessors, but it would be a remarkable book if it contained only the first lecture, which gives a review of the results of his former teaching in a very brief space. We translate a few of these points for the benefit of our readers.

He has recognized and described the sweating form of *typhoid fever* which is characterized by early and persistent perspiration, intermitting and irregular fever, the absence of abdominal symptoms, and its prolonged duration. This fever has not the peculiar diurnal variation of temperature that has been assigned it; its types are multiple, and they may be distinctly intermittent through its whole course. This last fact explains the inverse type, with a high morning and a low evening temperature, and invalidates this particular symptom as diagnostic of phthisis.

He has given clinical proof that in its degree, duration, and evolution, the *scarlatina* is beset with anomalies without being changed in its essential character; that the gravest symptoms may occur in cases in which the eruption is free and perfect, and that swelling of the joints and endocarditis are incident to this affection.

He has had renewed confirmation of the idea, which he advanced twenty years ago, that the first sign of the fit in *intermittent fever* consists in an increased excretion of urea, which may precede the advent of the chill by several hours,



and which furnishes a clinical indication for aborting it with quinine.

In respiratory affections he has described a *hemorrhagic, fibrinous broncho-alveolitis* which is common among consumptives, but which is not limited to them. By tapping the thorax with one puncture above another he has confirmed the value of the clinical symptoms of circumscribed or encysted pleuritic effusion. Anatomical proof has been furnished of the possibility of differentiating a limited pneumothorax from the cavernous pits of tuberculosis. A careful study has also been made of false pneumothorax and of abscess below the diaphragm.

In *affections of the heart and the aorta* it is proved that the dorsal aortic souffle may possibly cause a sternal souffle, whence it follows that the latter is a reliable sign of tricuspid insufficiency only when it existed without the former; and also that the systolic souffle in the second left intercostal space is not a certain sign of narrowing of the pulmonary orifice. The remarkable work of this *clinicien* in regard to mediastinitis has already been referred to in these pages (*Clinique*, vol. 9, p. 437). And here also we have the practical distinction between unicostal and pluricostal depression as a sign of adherent pericardium, the latter only being trustworthy.

Other practical points concern the undoubted possibility of severe jaundice from functional insufficiency (*acholia*) in all forms of hepatic cirrhosis; and the statement that the only positive signs of destructive lesions of the pancreas are those furnished by palpation, all others being merely presumptive. Two cases are noted and "improved upon," in which tuberculous meningitis in the adult was evolved under the mask of delirium tremens.

Concerning *albuminuria* and *Bright's Disease*, our author still insists, as he did in 1867, upon the plurality of these symptoms, and that there is no practical clinical distinction between parenchymatous and interstitial nephritis. He holds to the phrase "uræmic intoxication" instead of uræmia, and emphasises his original prescription of the inhala-

tion of oxygen in its treatment. There is also a careful study of three cases of *urinary tuberculosis* and of one of *renal syphilis*.

The possibility of a form of diabetes which depends upon the eating of a starchy aliment and the necessity for regulating the diet in genuine diabetes are insisted upon as they have been by the author since 1866.

An interesting item identifies a fever dependent upon chlorosis, which can only be cured by restoring the globular element to the blood; all of which is in striking contrast with the theory of Dr. Andrew Clark, that refers the production of chlorosis to torpidity of the bowels.

What is extremely rare, we find in these pages a perfectly appreciative account of the behavior of the bacilli in the various forms of disease in which they have been identified, and of their clinical significance. Those who have had most to say of these "beasts" (Tait) are constant sinners in respect of not telling us what to do with them, or whether their existence is a mere matter of morbid curiosity. Jaccoud has demonstrated their presence in the blood of the living subject in the course of mild and severe *mumps*, in which, in two cases he was the first to recognize an incidental endocarditis; in *urinary tuberculosis*; in general infection from *blenorragia*; in *pleurisy* developed during the existence of cancer of the stomach; in all cases of *fibrinous pneumonia*, for wherever there is hepatization in pneumonia the microbes are present, no matter what the clinical evolution of the disease may have been; in the form of *broncho-alveolitis* above referred to; in *infectious endocarditis* with its varied forms of bacilli; in *erysipelas*; and in *purulent infection* and *tuberculosis* following pneumonia.

The microbe of pneumonia is not exclusively proper to that disease, but is also found in the broncho-alveolitis occurring in phthisis, where both it and the tuberculous bacillus exist in the same subject. In infectious endocarditis the microbes are not always the same. *Apropos* of this we read :

“From these two facts, their plurality in the same affection, and the presence of the same microbe in different diseases, I conclude that certain microbes, which are really pathogenetic, do not always give rise to the same symptoms, and that we must therefore recognize two classes of them: (1) the *specific* microbes, whose effects are always identical, such as the microbe of tuberculosis and that of erysipelas; and (2) the *indifferent* microbe, whose injurious effects vary with the condition of the organism and with that of the tissues in which they are lodged, and wherein they proliferate, so that each of those microbes is common to several distinct diseases of which the pyogenic and the pneumonic bacilli are the best examples.”

The next paragraph is equally expressive and valuable: “I have proved that, whatever may be the future of bacterial pathology, *taking cold* must still be placed among the causes of acute disease, and especially of pneumonia. Indeed I have presented two cases in which a fatal attack of this disease was developed within twenty-four hours after a sudden chill experienced under very different conditions, and in two persons of robust constitution and of perfect health.” In these two cases the bacilli were discovered in the sputa and in the pulmonary exudation, a fact that could only be explained by the possibility of finding the pneumococcus in the healthy saliva (Fränkel & Netter), whence under the depressing influence and the organic perturbation of the chill they may have migrated and then caused the local mischief.

This illustrates what our author calls *intrinsic* infection, which depends upon the enfeebled power of the organism to resist the microbes that are carried within it, and which is the opposite of the *extrinsic* infection that depends upon their introduction from without.

He cites a case of infectious endocarditis in which the blood was examined and the number of contained microbes was found to diminish progressively with the disappearance of the acute symptoms under treatment. More than two months had elapsed after the case was practically cured,

when the patient suddenly died from cerebral embolism. At the autopsy there still were some microbes in the blood, in the endocardial vegetations, and in the tissue of the liver and the spleen, which microbes must have become innocent after the treatment and before her death from a contingent cause. Hence the practical inference that these breeders of mischief may become dormant and inert whenever the organism becomes able to resist them, as it does in health; and hence the following forcible propositions: "This *modifying power of the organism* is the means of cure in infectious diseases. If this treatment is questioned we must proceed cautiously, for in spite of experimental evidence, we shall be forced to acknowledge that at the outset the said microbes were innocent. As shown by our case of endocarditis this fact is important not only as regards that particular disease, but it also applies to the bacterial pathology in general.

"I consider this modifying capacity of the animal economy to be quite as important as the idea of an intrinsic infection. In the case of both, and in the face of recent discoveries, this view proves the supremacy of the living organism. For one shows its preponderating influence in the causation of infectious disorders; and the other demonstrates its importance as an essential source of curative indications, which are furnished by the patient and not by the microbe."

Finally he says: "I have been, I am, and I always shall be the foe of the anti-medical theories that tend to suppress the patient for the sake of the microbe; that endeavor to reduce pathology to the mere admission and penetration of microbes from without; that would limit diagnosis and prognosis to the detection and study of these microbes; that would circumscribe our therapeutics by indications which are drawn from the microbes; and that, in a word, would assume to change the medicine of humanity into that for the microbes!"

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## Miscellaneous Items.

The commencement of the "Old Halmemann" will be held in the Grand Opera House at 2 P. M. of February 21, the Valedictory to be given by Rev. C. G. Trusdell, D. D. The meeting of the Alumni Association is set for 8 P. M., of February 20, when the President, Dr. M. H. Parmellee, of Toledo, Ohio, will deliver the Annual Address.—A large attendance is expected and everybody interested is cordially invited to be present on both these occasions.—This is "Examination Week," and the boys and girls are pretty anxious.—Mrs. Dr. A. J. French is taking a merited vacation at Ocean Springs hotel, Miss.—Dr. E. P. Clapp, of Evanston, was married to Miss M. E. Norton, of Winona, January 23.—Dr. V. W. Stiles, the very efficient and acceptable House Physician of the Hahnemann Hospital during the past year has located in Riverside, Cal.—Our thanks are due for a number of complimentary letters concerning the new department of *Clinical Reviews* in this journal.—Prof. Hall gave the class a rousing good lecture a few days ago.—The medical tripod of the sixteenth and seventeenth centuries was *empiricism, dogma* and *aphorism*.—As usual the almanac fails to note that this is the season when the whole artillery of *Cram* is brought into action in the medical schools.—Prof. Bailey is the busiest man in Chicago, excepting Bros. Laning, Halbert, Fellows, Crawford and a half dozen others.—The new *Journal of Ophthalmology, Otology and Laryngology*, Dr. George S. Norton, editor, and Dr. Chas. Deady, assistant, published by A. L. Chatterton & Co., is out promptly, looks extremely well, and shows what Sheridan styled "A progeny of learning."—We should be guilty of a dyspeptic ingratitude if we failed to chronicle the retirement, because of ill health, of our friend Dr. Phil. Porter from the editorship of the *Hom. Journal of Obstetrics*, etc. In future that publication will be in charge of the publisher, A. L. Chatterton, of N. Y.—The papers read before the Clinical Society by Prof. Hawkes and Dr. H. P. Holmes, page 33, remind one of the saying of Voltaire that "Man is an animal made up of habits."—Don't forget that the next Post Graduate course will open on the evening of February 25, with an introductory by Prof. Arnulphy.

# THE CLINIQUE.

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## Original Lectures.

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### *ON "CLOSED ESTABLISHMENTS" FOR THE CURE OF PHTHISIS.*

A LECTURE INTRODUCTORY TO THE POST-GRADUATE COURSE  
FOR 1889 IN THE HAHNEMANN HOSPITAL, OF CHICAGO, BY  
PROF. B. S. ARNULPHY, M. D.

In the October number of the *CLINIQUE*, while attempting to give a digest of the positive results arrived at by the "Congress for the Study of Tuberculosis," held in Paris, July, 1888, I pointed out how poor and unsatisfactory were the reports on the therapeutics of that affection, compared with those on its etiology and pathogeny.

The only exception was in favor of the report presented by Dr. H. Frémy, of Nice, on certain "closed establishments" in Germany, where the phthisical patients, simply by virtue of a strict hygienic regimen, were cured in the proportion of twenty-five per cent.

These conclusions were confirmed by another distinguished specialist, Dr. Daremberg, of Mentone.

One may well wonder how it came to pass that such an important statement, made by men thoroughly versed in the difficulties of the question, should have attracted so little attention from the members of the congress, and excited so little discussion and comment.

But the French Government took the hint and immediately commissioned Dr. Frémy to come to this country in

order to observe and study how the ever-deepening problem of phthisis was understood and dealt with in this land of unprejudiced progress.

After having visited the Eastern States, Dr. Frémy, with whom I was on very friendly terms in Nice, came to Chicago and called on me. We had a long conversation, of which this lecture is the direct outcome. He gave me very valuable information on those German "closed establishments," in which for the sake of close observation he had lived for several months as an inmate, though not as a patient.

So far he had seen nothing of interest from his special point of view, and he appeared rather disappointed at the probable result of his mission to the United States. Dire mortality from phthisis all along the Atlantic coast, no attempt whatsoever at sanitary regulations respecting the contagion of that plague or its transmission from animal food, such was the scanty harvest he had gleaned.

He left after a few days for Denver, Col., and California, where he expected to find better material for study.

I thought it might interest you to know something definite about those "closed establishments," on what general principle they are founded, how they are run, and the results they yield.

First of all you will ask: "Why are such establishments termed 'closed?'" Because the patients are not allowed to go from them as they please. They are kept there under rigid rule and strict supervision, and I may as well state at once that this is by no means the least important part of the system. Generally, when a patient enters one of these establishments, he knows that he is not to leave it unless he is cured or dies. And as the cure seldom lasts less than from twelve to sixteen months, you perceive that no change of climate is needed for the cure. Now, are these establishments situated in particularly privileged locations, as far as the climate is concerned? Not in the least. No one would claim that the climate of North Germany is the ideal climate for phthisis. If we consider individually the four principal establishments of the kind, we find that Görbersdorf, the oldest of all, created by Brehmer,

is located in Silesia ; that Falkenstein, under the management of Dettweiler, is situated in the Taunus near Frankfurt ; that Reiboldsgrün, Ander Driver, is located in the Saxon Erzgebirge, near Dresden ; finally, that New Schmecks, under Szontagh, is located in the Carpaths.

A very moderate altitude, a site affording facilities for the creation of a large park, as much as possible in the vicinity of a wood, or of a forest protected from high winds, sufficiently distant from great centers of population, to be "Far from the mad'ning crowd's ignoble strife," such are the only requisites. Every country in the world affords plenty of sites, but none, perhaps, similar or more desirable than this vast country.

Now, in what does the treatment proper consist? Mainly of the four following essentials :

1. Rest in the open air.
2. Respiratory gymnastics.
3. Diet.
4. Hydropathy.

*1. Rest in the Open Air.*—What kind of air is best for the phthisical patient to breathe? That is the question. Here we find the same striving after a specific as is shown for the climatic influence. Thus, while Jaccoud affirms that the climate of altitudes is curative by its own virtue, G. See, somewhat biased by the infectious doctrine, claims that in order to be curative, the air must be entirely aseptic, that is, devoid of germs. Still the results obtained in the "closed establishments" show that all that is requisite is pure fresh air.

So much is demonstrated and admitted now-a-days that what the phthisical patient needs above all is fresh air, and plenty of it. In order, then, to supply that want in the best possible way, some special accommodations have to be provided, under the direction of experienced house-physicians. The best way, says Dettweiler, to get a patient accustomed to the outside air, is to have him stay out of doors stretched on a couch. There is no harm in it, if the subject be warmly dressed. It is worth while knowing that Dettweiler, formerly a phthisical patient himself, was cured by means of that simple method.



After a few days the habit is formed, and the patient has no wish to get back under cover. Little by little a sense of comfort develops, digestion and sleep improve, the fever lessens, the breathing becomes easier every day, and, most curious of all, the cough almost entirely disappears.

The weak and feverish patients are made to stay out in the reclining position as late in the day as possible, until they have gained strength and the fever has diminished. Even such patients as are obliged to take to their bed on account of extreme weakness and high fever, are not confined to their rooms; for the bed is pushed out on the verandah.

This plan is carried out all the year round: in winter time patients are thus made to stay out from 5 to 11 hours, in succession, the average being seven hours. Very frequently what might be called the medical day closes as late as 10 p. m. The patients then repair to their cool and thoroughly ventilated rooms.

When the weather is stormy, patients seek a shelter under large glass-roofed halls, opening on every side upon the garden, and where they enjoy the benefit of the open air in spite of dense fogs, snow-storms, or biting cold.

Dr. Frémy, in order to show what degree of endurance the patients can be made to attain in that line, cites the fact that in 1883 the Christmas and New Year's festivities were celebrated by the patients at the Falkenstein establishment under an open tent, surrounded by fir-trees that had been stuck into the deep layer of snow outside. Not one of them, however, was in any way harmed.

2. *Respiratory Gymnastics.*—As soon as the patients have grown stronger and apyretic under the influence of prolonged sojourn in the open air, they are allowed to walk in the park. Here every detail is calculated toward improving, little by little, the strength of the heart by moderate exercise without fatigue. The paths in the park have various grades of inclination that are adapted to progressive pulmonary gymnastics. But the greatest attention is paid to the condition of the heart all through that part of the training. In fact, the heart is here made the test of the amount of exercise to be allowed. The patients are

constantly under attendance; they are never allowed to fatigue themselves, as fatigue, especially of the heart, is harmful to the phthysical invalid, and always brings back the fever.

Besides the patients are taught to avoid perspiration. It has been observed that if a patient succeed for a length of time in keeping his skin dry, it will gradually lose its excessive sudoral propensity. This is one of the most characteristic details of the cure.

One thing too, struck Dr. Frémy. It is the care practiced in preventing patients from exposing themselves unnecessarily to the rays of the sun, as hemoptysis is very likely to occur from such exposure in predisposed subjects. To that end shaded lanes are provided in the park.

3. *Diet.* The air-cure, such as we have outlined it, is only a part of the system. The real difficulty of the treatment is to feed the phthysical patient. One point at least, is universally conceded, that this class of patients never eat too much.

There is no lack of reasons why appetite should fail them. First, he may have inherited the disposition from his parents, and from childhood he may have been a small eater. Then commonly the sensation of hunger diminishes in a direct ratio with inanition. Then again, as Bouchard has observed, most of the phthysical patients have more or less dilatation of the stomach.

Nevertheless, experience and observation tend to show that except in very unfortunate cases, the influence of the air-cure alone is sufficient to bring about a change for the better.

Dettweiler states that in the course of one year, fourteen per cent only of his patients, failed to show an increase of weight.

The average gain is six to eight pounds in a period of eighty days. Each patient is given a diet appropriate to his individual condition, tastes, amount of exercise, and so on. The principle most commonly applied is that of small, substantial and frequent meals, with a view to developing the digestive capacity in a continuous, progressive way.

What is aimed at by means of these dietetic contrivances, is not to gratify such or such an alimentary theory, but to avoid every possible error of diet, to remove the causes that may provoke or keep up anorexia, to overcome any prejudice that may stand in the way, and finally to *over-feed* the patient.

This latter is quite an art in itself. It is a matter of constant care and attention on the part of the physician. It is also a matter of education on the part of the patient. Nothing of the kind could be done either at home or in the common health-resorts. It is only the "closed establishment" that can afford such a methodical course.

4. *Hydropathy*.—I have little to say about this last means of cure. That it is powerful for good and for evil is generally recognized. The best authorities on phthisis are agreed on its efficacy, when properly applied, as recommended by Winternitz, Brehmer, Dettweiler, Sorgius, Soxolowski, Sontagh, Driver, Spengler, Bennett, Jaccoud, Peter, etc.

It is properly the complement of the inuring process to which these patients are subjected. From a statistical survey of the various establishments it appears that one-third only of these patients is thought fit to receive the douche.

You readily understand what amount of prudence, care, competence and experience such treatment requires at the hands of the attendant who dispenses it. Here, again, we must realize that it is only a thoroughly trained and skillful house-physician who can assume such responsibility.

I can not close this rapid survey without pointing out one of the most remarkable consequences of this hygienic treatment, namely, the physical and moral education that the patient receives thereby. Through personal experience, multiplied by that of his fellow-companions, by friendly intimacy with the house-physician, he has gradually acquired the exact knowledge of what he can and of what he can not do. He learns that the slightest imprudence may have the worst consequences. He has learned how to measure his own strength, and how to regulate its expenditure. He has been taught that henceforward his life will

depend upon his conduct. He realizes the full meaning of the sentence, "*L'homme meurt de son caractère.*"

No medicinal treatment whatever is used, except for unusual complications. Thousands of patients have been treated in these institutions, with uniformly good results; as an average, twenty-five per cent are cured; in a much larger proportion relief is obtained and life prolonged. Now, if we reflect that their "*clientèle*" is mostly recruited among desperate cases, we can not but acknowledge the efficacy of the method. For where is the practitioner who can boast of achieving such results?

It strikes me that such a method of cure, so rational in its principles, being outside the pale of the schools, and having, therefore, no doctrinal argument to contend with, ought to be universally recognized and adopted, until we can find something better.

This method was originated by Brehmer, who, as far back as 1854, proclaimed the curability of phthisis by hygienic means, in recompense for which he was called a quack.

It is not my purpose here to go into more details about these establishments. What we must retain of this brief outline is that they are successful. It is therefore important to study the reason for that success, and that reason we find in the method that is followed.

Let us specify. Could we claim that the climatic treatment of phthisis as it is currently practiced is a method? Some doctors will confidently send their phthisical patients to southern latitudes, some to bald, frigid localities, some to the sea-shore, some inland, some on a long sea-voyage; some will perch them on the highest peaks they can find, some confine them to low, warm valleys.

Others again, who are fond of change and experiment, will think proper to have their patients run the whole gamut of climates, one after another. In fact, this procedure almost becomes a necessity for those patients who have spent the winter at one of the Southern resorts. At spring time they are compelled to seek some less burning atmosphere, and so on at every turn of the season.

How far it is possible to follow a methodical course of

treatment, under such trying circumstances, I leave for you to judge.

*Hygiene*, we have seen, constitutes the fundamental principle of treatment in the "*closed establishments*;" that hygiene which Bouchard rightly proclaims "the best curative agent in our possession."

Of course, but if we endeavor to apply it to the cure of phthisis we must do so systematically and methodically.

If so, then hygiene becomes too ponderous an instrument for a phthisical patient to wield for his own benefit. Hence the necessity of such establishments as I have described, where all that pertains to hygienic therapeutics can be practiced and taught by competent physicians, the patients having nothing else to do but to obey instructions. Hygienic therapeutics make no further pretense than to render the infected organism able to defend itself; and to cure it by means that have nothing specific about them.

It follows that those authors who seek a curative agent in the climatic influence must be prepared to meet with very scanty success. Such is the case with the patients who flock to the altitudes of Davos, Samaden, Saint Moritz, which Jaccoud recommends as being *curative*. No doubt a certain class of scrofulous or bronchitic subjects, with suspicious antecedents, or such as are only predisposed to or convalescent from the disease, may find the mountainous climate quite beneficial. Such people are not actually sick. The go-as-you-please system followed at the popular resorts may suit them, or not positively harm them. But take tubercular subjects, where consolidation or softening have set in, and the position is very different. Here the "closed establishment" becomes a requisite, because these patients have to be protected against themselves; they must be taught how to behave. The physician who sends his phthisical patient to a health resort does not usually know what he is doing; he is always making an experiment.

With the "closed establishment" there is no longer any uncertainty. The physician there knows what he is about; his work lies clearly before him. Everything is sharply defined and precise in the method he follows. The patient

sent there stands a good chance of finding his way home, which is not reasonably to be expected of phthisical invalids starting for sunny shores or frosty summits. "For three years," says Dr. Frémy, "I have spent my summers in visiting these establishments; I have spent months in most of them, and I have formed the conviction that they render such service that if there be diseases fit only to be treated in special establishments, phthisis is one of them, most assuredly. It is a complex disease—a disease unlike any other. It therefore requires a special treatment. Little does it avail to run far or near in search of such or such a climate. What the phthisical patient wants is rest in an institution where he shall be subjected to a methodical treatment, physical and psychical. When the antiseptic cure for tuberculosis is found, which may be in the near future, this moral and hygienic treatment will lose none of its value."

It is therefore highly desirable that establishments similar to those that are doing such remarkable work in Germany, should be founded everywhere.

Why should not this Government look into this matter seriously, and commission a few competent physicians to visit Germany with a view to studying the method of phthisiotherapy in use in those special institutions?

If half a dozen such institutions were founded in various sections of this country, and run on sound principles, thousands of valuable lives could be saved every year.

It may not be devoid of interest to know that the German establishments are very successful in a pecuniary way, and that their managers derive a handsome income from them.

If we reflect that phthisis is relentlessly mowing down day by day the worthiest part of our population, in the proportion of one-fifth of all the causes of death; that no satisfactory medicinal treatment has yet been proposed; that the climatic treatment is a dangerous illusion, and a costly one, we must come to the conclusion that the hygienic treatment according to Brehmer's method deserves better than silence and a lack of recognition.

## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

FEBRUARY MEETING, 1889.

The regular monthly meeting of the Clinical Society was held in Parlor 44 of the Grand Pacific Hotel, on Saturday evening, February 23, 1889. In the absence of the President and Vice-President Dr. A. K. Crawford was called to the chair. The session was devoted to the report of

### *THE BUREAU ON THE DISEASES OF CHILDREN.*

DR. SHELDON LEAVITT, CHAIRMAN.

This very interesting report consisted of the four following papers :

I. SIMPLE IDIOPATHIC CEREBRAL MENINGITIS.—By S. LEAVITT, M. D.—*Case.*—G. M—, a boy of eighteen months, with unusual cerebral development, was taken on January 14th last, while in apparent good health, with what appeared to be gastro-enteritis, accompanied with considerable pain and vomiting. This condition continued during the day and evening, and was followed by a restless night. In the morning he seemed to be in less pain; there was diminished fever, and bowels were moving at longer intervals. His symptoms softened somewhat in intensity during the day, and the succeeding night was passed in more comfort. On the sixteenth there was little fever; the bowels were moving infrequently, but the stools were still thin. He was indisposed to receive even the loving ministrations of his mother, but desired to be quiet. He cried on being raised, even to a sitting posture.

The succeeding night was restless, and when I saw him on the morning of the 17th there was same tympanites; pulse 130, temp.  $100\frac{1}{2}^{\circ}$ . During the day he seemed fairly comfortable, but drowsy, while the countenance presented unusual pallor. He was quieter than common during the night, and when I visited him on the morning of the 18th there was evidence of a decidedly unfavorable change. The temperature had risen to  $104\frac{3}{4}^{\circ}$ . At 6 p. m. he was sleeping

heavily, the abdomen was tympanitic and the pallor of the face was increased.

At 8 p. m. Dr. Delamater was called in consultation, and he met me every evening for several succeeding days. The symptoms had not materially changed. On the 19th, at 8 a. m., the pulse was 76, temp.  $103^{\circ}$ . He had vomited two or three times, and the bowels had moved once. There was diminished abdominal tympanites.

At 12:30 pulse was 116, temperature  $103^{\circ}$ . At 3:40 p. m. I found that he had been sleeping some time. The eyelids were partly closed and eyes suffused; pulse 110. At 8 p. m. we noted no material change. At 8 a. m. of the 20th, pulse 80 (doubtless being reduced by *veratrum viride*) temperature  $102\frac{1}{8}^{\circ}$ ; still comatose; pupils rather broad, and respond slowly to light. At 6 p. m., no material change. 21st, 10 a. m., temperature  $101\frac{1}{8}^{\circ}$ , pulse 80. Has urinated twice, though not previously for twenty-four hours. 2:30 p. m., temperature  $101\frac{1}{8}$ . Wakens at times, with a conscious expression of countenance. Pupils smaller, and respond better to the light. Abdominal tympanites has now disappeared. At 10 a. m. of the 22d, temperature  $102\frac{1}{8}^{\circ}$ , pulse 100. I found that he had passed a very restless night. 2:50 p. m., temperature  $102\frac{1}{2}^{\circ}$ , pulse 76 (probably the result of *veratrum viride*). Passes urine, and bowels move two or three times in twenty-four hours. 10 a. m. of the 23d, temperature  $102\frac{1}{8}^{\circ}$ , pulse 120. Seems a little brighter. 4 p. m., temperature  $102\frac{1}{2}^{\circ}$ , pulse 100. (Had had no *veratrum viride* for about twenty-four hours.) Pendulum-like movement of left arm. 10 a. m. of the 24th, temperature  $101\frac{1}{2}^{\circ}$ , pulse 100. Seems better. 2 p. m., temperature  $104\frac{1}{8}^{\circ}$ , pulse 100; quiet and restful. 9 a. m. of the 25th, temperature  $102^{\circ}$ , pulse 110. Cries and had a very restless night. 7:30 p. m. No noticeable change. 10 a. m. of the 26th, temperature  $101^{\circ}$ , pulse 130. Had another restless night. 3 p. m., temperature 101, pulse 112. Cross and fretful, but mind has evidently been fairly clear for twenty-four or thirty-six hours. 10 a. m. of the 27th, temperature  $98\frac{1}{8}^{\circ}$ . Had a very restless night. Stools more consistent, but whitish in color. 6 p. m., about the same.

From this time forward improvement was satisfactory, though for many nights he was exceedingly restless and almost unmanageable. At present writing he is in good health. Various remedies were administered. *Veratrum viride* manifested its characteristic effects, and I believe was of considerable service. *Helleborus* served a good purpose, not only in relieving cerebral symptoms, but also in overcoming urinary suppression. *Calcarea carb.* was given at intervals throughout the illness. On the evening of the



25th *aconite* was indicated by thirst, extreme restlessness with agonizing tossing about, and its effect was marked. *Apis*, *veratrum album*, *chamomilla*, *bryonia* and *podophyllum* were used for short periods. No local applications were made.

*Remarks.*—I regard the foregoing case as one of “simple idiopathic cerebral meningitis.” This form of meningeal inflammation is comparatively uncommon, far more so than the tubercular variety. It will be observed that this disease is wanting in the direction of prodromi, which so uniformly usher in tubercular meningitis. It may be said to lie between the latter form of meningeal inflammation, and that arising from traumatism. The attack is usually rather abrupt, intense, and comparatively brief, as in the case just reported. The temperature is likely, at the same stage of the disease, to rise higher than in the tubercular form, and its illusive abatements are not as decided nor frequent. As might be supposed, the simple and the glandular forms are not always easily differentiated. Indeed, these diseases, like most others, do not follow a uniform course, and present unmistakable symptoms. In the early stage of the disease, confusion may arise from there being more or less prodromi in connection with the idiopathic form, while in a case of tubercular meningitis they may be less distinct than usual. During the progress of the foregoing case, before clear improvement began, strong suspicions that I had to do with ordinary acute hydrocephalus began to take shape in my mind. Had not improvement set in as it did, I should have made a careful microscopic examination of the patient’s blood for differential purposes. In tubercular meningitis the relative number of white blood corpuscles is increased, and amœboid activity is increased. In those cases where a positive diagnosis can scarcely be made, we usually exclude tubercular meningitis if the patient chance to recover, since this form of disease is, by some, regarded as absolutely incurable.

The prognosis, in cases of idiopathic cerebral meningitis, though grave, is not by any means hopeless. Seven or eight per cent of them recover, and homœopathic treatment may possibly raise this percentage, though probably

not to any great extent. This form of meningeal inflammation has also been termed leptomeningitis, from its involvement of the arachnoid and pia mater. In view of the delicate structures attacked, and their close relations to the brain, we can not wonder at the fatality of the disease.

In the way of treatment I am not sure that anything new was developed, but it was plain that well-known indications, when followed, are capable of leading us into a useful exhibition of remedies.

DISCUSSION.—DR. C. S. MACK referred to the possibility of recovery from tubercular meningitis. Cases have recovered where tubercles have been seen on the retina. We know also that cases of tubercular peritonitis have gotten well after an operation where tubercles have been shown to exist on the peritoneum.

As I understand it, we have no right to conclude that a case of meningitis was not tubercular, simply because it recovered under the appropriate treatment.

DR. A. K. CRAWFORD made the following inquiries of the essayist: Do you consider the reduction of the pulse in each instance to have been due to the action of the remedy administered? Do you think that, had this drug not been used, the pulse would have been continuously high? Did you notice whether there was a corresponding depression of the temperature when the pulse dropped? Lastly: As the case began with such pronounced abdominal symptoms, have you any reason to think they ran along with and complicated the meningitis?

DR. LEAVITT.—Whenever we let up on the use of *vera-trum vir.* the pulse would run up to 120, or more. We used Norwood's tincture, putting eight to ten drops in two or three ounces of water, and administered it in teaspoonful doses, giving explicit directions when its use was to be stopped. One night vomiting and purging were very marked, going on nearly to collapse.

The temperature was reduced together with the frequency of the pulse, but not always in the same ratio. There was no evidence of paralysis. The child laid on its left side for several days and did not want to be moved, still it could move any of its limbs.

With relation to the encephalic cry, my opinion is that it is more especially characteristic of tubercular meningitis.

II. CEREBRO-SPINAL MENINGITIS.—BY DR. CORA E. TAYLOR, OF ENGLEWOOD, ILL.—*Case*: I was called, on the 13th of January, to see Grace ———, a frail-looking, slender, blue-eyed child, aged three and a half years. The parents reported that two days previously the child had had a hard chill, followed by a high fever, obstinate vomiting and stupor. They had diagnosed worms, and had tried some domestic remedies, with no effect. When I saw her, her temperature was  $101\frac{3}{8}^{\circ}$ . She was still sleeping heavily, but when aroused complained of pain in her head and stomach, and occasional nausea. I prescribed *belladonna* and *nux vomica*.

On the morning of the 14th I found the patient better. The temperature was  $99\frac{1}{8}^{\circ}$ . She was awake, had taken some nourishment, and was much brighter. Continued the same remedies. On the 15th I was notified not to call, as the child appeared nearly well. She was reported as sitting up, eating a little, sleeping more naturally, and without fever.

On the evening of January 16th I was suddenly summoned, and found her very ill. Temperature  $104\frac{1}{8}^{\circ}$ ; pulse 140 and very weak; the pupils were contracted, with stertorous breathing, and a marked contraction of the post-cervical muscles. I prescribed *veratrum vir*.

January 17th, at 9 A. M., I found her much worse; temperature  $105\frac{1}{8}^{\circ}$ , pulse 148, marked opisthotonos, partial paralysis of the muscles of deglutition, and complete unconsciousness and stupor. At 5 P. M. there was considerable amelioration. The temperature was  $104\frac{1}{8}^{\circ}$ . She was able to swallow the medicine, and could be aroused for a moment.

January 18th to 21st.—The case ran about the typical course, there being present all the time obstinate constipation and herpetic spots on the face, and stupor; the opisthotonos gradually decreased, and the fever remitting, varying from  $103^{\circ}$  in the morning to  $102^{\circ}$  in the evening. During this time I continued the *ver. vir.*, *bryonia* and *helleborus*, with occasional doses of *gelsemium* and *sulphur*.

January 21st—Dr. Leavitt was called in consultation.

January 31st—The condition of the patient remained unchanged, except that there was retention of the urine from paralysis of the bladder. We drew off about two ounces of urine which was heavily loaded with albumen and the amorphous phosphates. *Hyoscyamus* and *belladonna* were prescribed.

February 1st to 3d—Slight improvement, the fever falling to  $101^{\circ}$  in the afternoon.

February 4th—Still improving. She was conscious at times, and would occasionally remain awake for as much as half an hour at a time. The bladder resumed its function. The fever broke on the 6th, and the symptoms gradually disappeared. At this writing, February 23d, the patient is convalescent, with no discoverable sequelæ.

III. SCARLET FEVER AND MEASLES OCCURRING SIMULTANEOUSLY IN THE SAME PATIENTS. *Case 1.* Milton, aged 4 years and four months, the third of a family of four children, was taken ill Tuesday, January 17. Complained of nausea, sore throat, and fever. The next day his face and limbs looked red, but the parents thought it was only occasioned by the fever, and did not send for me until the 21st, when I learned the above. I was also told that he became pale again in two days, and had not been feeling as well since. When I saw him he looked ashy pale, pulse 140, skin dry, throat normal, thirsty and no appetite. Ordered him to be wrapped up well and hot drinks given, in order to cause perspiration and possibly the reappearance of the rash. The next morning the rash showed faintly on the arms and lower extremities, but only for a few hours, but enough to make out a scarlet fever eruption. The pulse remained high, the tongue coated, and he felt very sick, an indication that something was to follow. And it did. By the next day rheumatism, involving the hands and feet had developed, which lasted for some days. After that acute Brights disease with anasarca and ascites, and by the time that was about controlled, which was three and a half weeks from the time that he was first taken, he began with the catarrhal symptoms of measles and in three days more (February 13) the eruption appeared and the disease ran its course without any more complications. Now, February 21, he is about well.

*Case 2.* Otto, aged eight years, January 30, began to complain of the common symptoms preceding measles, such as: fever, dry, irritating cough, conjunctivitis and nasal catarrh. The next day, January 31, I saw four distinct measles-spots at the soft palate. There was no congestion of the palate or pharynx, but those spots, as large as the head of a common pin, were there very plain, and I expected the eruption to make its appearance in about twenty-four or thirty-six hours. But the next morning I found to my surprise, the soft palate generally congested and covered with a fine rash, as we see in scarlet fever. The same afternoon the boy vomited, complained of sore throat,

high fever, and the next morning (February 2), the fourth day since the beginning of the measles symptoms, and twenty-four hours after the scarlet fever symptoms had appeared, the two eruptions made their appearance simultaneously. There was not the smooth eruption of scarlet fever, nor any isolated measles spots, but the scarlet rash apparently "filled in" so as to cover the places left free by the measles. Considerable pharyngitis had developed, with some exudation on the tonsils, which was controlled very readily by the appropriate remedy. From the time the eruptions appeared the boy grew steadily worse; typhoid symptoms developed, such as dry tongue, lips covered with sordes, delirium, coma and death five days after the eruptions showed first. Dr. Schneider, who saw the patient with me the day before death, agreed perfectly with my diagnosis.

*Case 3.*—Newton, aged 6 years, started with the prodroma of scarlet fever, February 10th. The next day the eruption manifested itself, but not very plentiful, pharyngitis, with some exudation on the tonsils, the tongue moist, coated white, pulse 140, dry, irritating cough, and some nasal catarrh, which made me feel that he also would soon have measles.

February 12th—Eruption same on body, but pale on face, where, by night, it had disappeared entirely. Throat better, tongue cleaning off, pulse 140, catarrhal symptoms worse, and is sneezing frequently.

February 13th—All symptoms about the same, but measles eruption appear in face. 9 P. M., is somewhat delirious; there is glandular swelling on right side of neck; measles eruption more on body.

February 14th—Had a restless night, tongue dry and hard, lips covered with sordes, fetid breath, pulse 130, stupid, but could be aroused, and would answer questions correctly; scarlet fever eruption paler, but measles more prominent. I saw him again at 6 P. M. with Dr. Leavitt, when he seemed somewhat improved; the tongue was not so dry, the lips were cleaner, the breath not as offensive, and the sensorium some clearer; pulse 120.

After that there was gradual improvement of all symptoms. He slept a great deal for several days, and could hardly be aroused to take nourishment or medicine for six hours at a time. So far no new complications have developed, except an otorrhœa of the left ear. His appetite is good, and desquamation progresses as usual.

*Case 4.* A little girl, the youngest of the family, aged 2 years and 7 months, has so far only had measles, showing

the first symptoms about February 10, eruption manifesting itself February 13, and has apparently recovered.

*Remarks.* The above cases show (1) that when a child has contracted either scarlet fever or measles, it is still susceptible to the contagion of the other.

(2.) The possibility of these two diseases running their course simultaneously in the same patient.

Most physicians doubt this, and many declare it to be impossible. So would I have done a month ago, and when I first saw it could not believe it but thought I must be mistaken, until the conviction was forced upon me.

These children went to school at different places. Milton, Case 1, to the kindergarten, where he likely contracted scarlet fever. Otto, Case 2, went to public school when he came in contact with measles, and his brother, Milton, communicated his scarlet fever to him after already having contracted measles, as the period of incubation is shorter in scarlet fever, and just in time to have the two diseases appear simultaneously. In return Otto communicated his measles to the other three at the same time that they were all sick together. Not so the scarlet fever. Otto (Case 2), was taken sick two weeks after Milton (Case 1), and Newton (Case 3), ten days after that; so he probably contracted it from Otto, Case 2.

It also shows that when the two diseases run their course together the prognosis is extremely unfavorable, as the one case where they did so died, and the other would probably have terminated the same way had the eruption appeared at the same time; but improvement began as soon as the first eruption began to vanish, and the case only appeared unfavorable as long as the two eruptions were in full bloom.

DISCUSSION.—DR. J. P. COBB: I have never seen the eruptions of scarlatina and measles appearing simultaneously. I have seen the eruption of scarlatina follow within a week, the disappearance of the rubeolous eruption, demonstrating to my mind that both affections must have been incubating at the same time. I had presumed that the efflorescence of the one was in some way inhibitory of the other.

DR. LEAVITT: This has long been a mooted question. I never saw anything like it before, and yet in the case that I saw with Dr. Poppe there certainly could be no doubt of their simultaneous existence.

DR. MACK: This was certainly a very interesting paper, but I should like to inquire, what reason there is why the two diseases can not exist together, and what ground there is for doubting the authenticity of such cases?

DR. J. B. S. KING: Such an inference may possibly have been drawn from a paragraph in the *Organon*, where it is stated that a chronic disease may be held in check or cured by the development of an acute one; and also that diseases are cured by the action of similar drug diseases. He would like to know how one can always tell the difference between the two particular eruptions?

DR. R. LUDLAM had treated such twin cases as those reported in Dr. Poppe's paper, and was of opinion that there is nothing impossible or strange about their occasional occurrence. We know that the scarlatina and diphtheria may coexist as well by the mingling of their symptoms, as by the crossing and the succession of their sequelæ. Besides, if these affections are specific, each having its own bacillus, we know that there may be, and frequently is a plurality of microbes in the same subject. Given a low state of vital resistance in a child, or in the children of a family, it is easy to suppose that the infection of two or more diseases might be developed at or very near the same time.

DR. DUNN: I have seen a plainly marked case of scarlatina and diphtheria, the scarlatina breaking out three or four days after the diphtheritic deposit had appeared in the throat.

DR. CRAWFORD: What other symptoms of scarlatina had your patient beside the eruption?

DR. DUNN: The characteristic eruption, with a burning heat of the skin, a high temperature and subsequent desquamation.

DR. MACK: What are the effects of suppressed eruptions? Have we any right to attribute bad results to the disappearance of an eruption? It does not seem to me that there is any logical reason for so doing.

DR. BELLE L. REYNOLDS: I must differ from the last speaker. My experience is, that such a suppression is almost in-

variably followed by bad results, and that, especially when the eruption disappears as the result of a chill, or of taking cold, we are likely to have a serious complication.

DR. KING: A case of scarlatina which I watched to its close, and which terminated fatally, is in the line of this argument. The eruption appeared all over the body, and the child was as red as a boiled lobster. Within twelve hours the eruption disappeared, the skin becoming as pale as it was red before, and coincident with this change was the rapid onset of severe brain symptoms.

DR. McCracken: I recently saw a case of scarlatina where the eruption wholly disappeared during one day and reappeared during the night after the use of Bryonia.

IV. ADENOID GROWTHS IN THE NASO-PHARYNX OF CHILDREN.—By DR. W. A. DUNN.—*Case 1.*—Clara C—, an anemic American child, seven years of age, with mouth agape, and oral breathing. Appetite poor; a general appearance of bad nutrition and scrofulous diathesis. Applied for treatment November 20, 1888. She spoke with a dull nasal tone; had a heavy, stupid expression, with drooping eyelids, pointed nose and depressed chin. She could not sleep soundly, because of the mouth-breathing, which caused her to snore and toss about the whole night. She was annoyed by a loose cough at night, as if there was much mucus in the throat, but none was expectorated. There was no pain, and very slight secretions from the nose. By anterior rhinoscopy the nares appeared quite normal, and did not show any obstruction to normal breathing. Inspection of the pharynx showed the tonsils to be slightly enlarged, on account of having had several attacks of tonsillitis since having scarlet fever two years ago, from which time her mother dates the nasal stenosis.

The soft palate was congested, and behind it could be seen hanging a collection of clear gelatinous secretions, which was being squeezed from the naso-pharyngeal region by the contraction of the soft palate. Posterior rhinoscopy being impossible, because of the narrow opening and the spasm of the throat, it was necessary to examine the region behind the soft palate with my finger. On examination, I found the whole of the naso-pharyngeal space filled with rather soft nodular growths hanging from the roof and posterior wall of the naso-pharynx.

The diagnosis being adenoid growths in the naso-pharynx, we removed the whole mass at one sitting with



the post-nasal forceps. The after-treatment consisted in spraying the throat with listerine until the parts were quite healed. *Ars. jod 6* was given internally.

Her improvement was very rapid; she could at once breathe through the nose; she soon slept well; her appetite returned, and she is quite developed into a strong, healthy child.

This is a fair example of many cases we meet among children, and we find that but few practitioners are able to distinguish these cases from the many other diseases that are taken to be nasal catarrh, and put down in their list as incurable. I have tried to impress on our class this year the imperative necessity of distinguishing the many diseased conditions that are usually supposed to be catarrh, and especially not to rely on the patients' own diagnosis of this dread malady, who too often has a "black bat" in his head, a "smoke ball" in his pocket, and a hypertrophy of some kind in his nose, or naso-pharynx.

*Case 2.*—Agnes B., aged 6 years, German, apparently of a scrofulous diathesis. Some months ago, while eating her dinner, she swallowed a larger piece of meat than was her custom, to which was attached a small piece of bone. This seemed to stick in her throat, and she was brought to see if there was not a piece of it remaining, as, ever since, she has complained of pain on swallowing, and has been unable to breathe through the nose. The other symptoms were about the same as Case 1.

On examination I found some pharyngitis, and the whole of the naso-pharynx filled up with the adenoid vegetation. This mass was removed with the forceps, and all her symptoms disappeared in a few days.

This condition had existed long before the accident at the table, but that was the first to bring their attention to the condition of the nose and throat, and of course to it they attributed all the trouble. I found, by examination, two other children in this family suffering from the same form of trouble, but not to such an extent as to close up the choanæ.

*Case 3.*—Carrie S., 15 years old, Polish Jewess, was sent to the clinic that she might have her tonsils removed, also a nasal polypus from which she was supposed to be suffering. For eighteen months she had been unable to breathe through the nose. She was unable to sound many letters, and her language was quite indistinct. By examination I found the nose free from any obstruction, but the naso-pharynx entirely filled, as in the other cases.

The tonsils were very large and extremely indurated, and as she had been under homœopathic treatment for a long time without their being diminished, I excised them at once. As she could not return soon, the adenoid mass was not removed until a couple of months later. The results were most perfect. She could at once breathe through the nose in a normal manner, and in a few days the speech was entirely restored. This case illustrated the necessity of the after treatment. She did not return for four or five days, when she came in with a very bad odor from the nose, which was at once relieved by the Listerine spray.

*Case 4.*—Herbert G., seventeen years old, had not yet learned the use of the nose as a respiratory organ, as he could not remember that he ever breathed through it. He was a marked example of the mouth breather, pointed nose, drooping lids and chin, and a narrow-contracted chest. He came with the usual question, "Can catarrh be cured,"—the same the family had been asking for many years.

His speech was so indistinct that he could not attend school. His hearing was very dull because of occlusion of the Eustachian openings. There was a thick gelatinous mucous discharge from behind the soft palate, and a general feeling of lassitude, with headache and roaring in the ears. I removed the growth with the cutting forceps at one sitting, and I shall not forget the expression of surprise and gratitude depicted on the boy's countenance when he found he could close his mouth and breathe easily through his nose.

In a very short time his speech was perfect, his sleep was good, his general health improved, his hearing quite restored, and the headache disappeared—in fact his so-called catarrh was very easily cured.

*Remarks.* These cases are sufficient to illustrate the necessity of proper diagnosis, and the ease with which many of these supposed incurable cases can be relieved.

It was not until 1868, that Luschka described this glandular tissue at the arch of the naso-pharynx; and Mayer, of Copenhagen, was the first to give his observations of an extensive number of cases in 1870.

This tissue varies much in the normal condition, and may be smooth or irregular, and full of crypts as in the pharyngeal tonsil. There is a great tendency to take on a

hypertrophic condition as like all such tissue, once it becomes inflamed there is but slight tendency to reabsorption, and by repeated attacks it is soon very much increased in size, so that we find it filling up the whole of the post-nasal space.

There is but slight if any tendency to ulceration. It occurs as a rule in children, and more frequently in females.

It is no doubt often hereditary, or due to a scrofulous diathesis, as we often find three or four children in the same family, suffering in like manner. The most frequent symptoms are those that come with occlusion of the nasal openings. Dullness of the voice with thick speech, nasal breathing impeded or entirely absent. Discharge of thick, tenacious, gluey mucus from the post-nasal space. Often dullness of hearing, with roaring in the ears. The mouth is open, and in long-standing cases there is a silly expression to the countenance, being the usual inheritance of the mouth-breather.

The patient sleeps poorly, snores and gasps during sleep, and awakes with a dryness of the throat which brings on pharyngitis and laryngitis. With the rhinoscope you see an irregular cushion on the roof and posterior wall of the naso-pharynx, or clusters of rounded pinkish bodies, hanging from the arch. With the finger you may feel the mass, in those cases in which you can not use the mirror. The treatment may be medical or surgical. Medical treatment is much the same as for hypertrophy of the pharyngeal tonsil. Much can be done during the acute inflammation to prevent the hypertrophy as well as by the prophylactic constitutional treatment. The growth may be removed by the finger, cutting forceps, curette, cautery or snare, but I usually prefer the forceps.

VOLUNTEER PAPERS.—A COMPARISON OF THE MORE IMPORTANT URINARY SUGAR-TESTS. BY J. B. S. KING, M. D. While we possess several absolutely reliable and very delicate tests for Glucose when dissolved in pure water, it is an unfortunate fact that when applied to organic fluids, such as exist in the body, their reliability and accuracy become greatly impaired.

Trommer's test, for instance, will, according to Dalton, show one part of glucose in 10,000 of water, yet when applied to urine it can not be depended upon to detect 10 times that amount in 10,000, the reason being that some of the normal ingredients of the urine, especially creatinin, exert a reducing action upon copper salts, and thus throw a doubt upon the result. The same is true of the other tests which depend upon the reduction of a metallic salt.

Trommer's test is performed in the following manner: A few drops of a ten per cent. solution of cupric sulphate are added to a small quantity of the urine contained in a test-tube, and then about one-third its volume of solution of potassa. The addition of the latter turns the liquid to a deep blue color. Upon bringing it to the boiling point, if sugar is present in any considerable quantity, a precipitate of cuprous oxide, varying in color\* from tawny yellow to brick red, is thrown down.

As before stated, this reaction can not be depended upon when only small quantities of glucose are present; in that case no such precipitate occurs, the test liquid merely turning from blue to a pale yellow, and exhibiting a flocculent sediment of the earthy phosphates. Moreover, exactly the same result is produced by urine *free* from glucose, if of moderately high specific gravity. It is, therefore, neither sure nor searching. For some reason this test has long been a favorite, and up to within a few years was probably more used by physicians than any other. Many healthy people have, no doubt, been pronounced glycosuric or worse, diabetic, upon its insufficient evidence.

A much more searching and reliable method of recognizing the presence of glucose is by means of Fehling's test, which consists of rochelle salt and cupric sulphate, dissolved in a solution of soda. The great objection to it has always been that it rapidly deteriorates and becomes unreliable, and hence is apt to be misleading.

Various methods have been proposed to overcome this objection, of which the best is to make two solutions, one of the cupric sulphate, and one of the alkali and tartrates. These solutions keep indefinitely, and, when mixed in equal volumes, furnish Fehling's solution in a perfectly fresh and reliable condition.

Physicians who have been misled by Trommer's test have heaped a certain amount of opprobrium upon Fehling's solution which it does not deserve. Both tests, depending upon the reducing action of glucose upon a copper

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\* The yellow precipitate is hydrated, the red anhydrous.

salt, they have been confounded, and the unreliability of one charged against both.

The rochelle salt is added to prevent the reducing action of creatinin and other organic bodies, which interfere with the reliability of Trommer's test.

The proper method of making this test is a little circumstantial and tedious, but as accuracy is more important than convenience, it should not be considered an obstacle.

The operator should set before him the two solutions, a cubic centimeter pipette, a glass of water (distilled water is preferable but pure drinking water will do), and the urine to be examined.

One c. c. of the Copper Solution is measured into a test tube, then one c. c. of water, then one of the Alkaline Tartrate Solution, then one of water, and finally one of the urine. The result is two c. c. of Fehling's Solution mixed with two of water and one of urine. The mixture is now gradually brought to the boiling point; the presence of even minute quantities of glucose will be shown with great certainty by the occurrence of the characteristic precipitate. When the amount is one-half of one per cent or over, the change occurs with great readiness, and is evident to the most careless eye. When the amount is less the result is less evident, and when it gets down to one-tenth of one per cent, or ten parts in 10,000, which is the practical limit of the test, the liquid does not lose its color, but after boiling a few seconds becomes of a greenish turbidity; but on allowing to stand for some hours, a scanty but characteristic sediment of the cuprous oxide will settle to the bottom of the tube. The greenish turbidity without this precipitate, does not prove the presence of glucose.

When these solutions are made according to the formula usually found in the text-books,\* they make a volumetric Fehling's Solution, each cubic centimeter of which is exactly reduced by five milligrammes of glucose, and they can therefore, with the aid of a suitable burette, be used for making a quantitative analysis.

Very rarely peculiar specimens of urine are met with which contain no sugar, and yet do yield a precipitate of cuprous oxide with this test. The majority of such cases reported are in all probability due to unskillful manipulation, rather than to the short-comings of the test. This view is confirmed by the fact that nothing is more common than for students in the laboratory to report affirmative results when using this test with non-saccharine urine. Still

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\*See King's Practical Urinalysis, card 6; or Sutton's Volumetric Analysis.

a number of undoubted cases have been reported, in which it has failed. Making due allowance for such cases it may still be said, without fear of contradiction, that this test affords a very high degree of probability, though not absolute certainty of the presence or absence of glucose, and that its delicacy is as great as need be for practical purposes.

Nylander's modification of Boettger's test is worthy of consideration. Briefly, it may be said to slightly excel Fehling's test in delicacy, to greatly excel it in convenience, and to fall somewhat short of it in certainty. Yet the cases in which it is uncertain may be so easily excluded that they hardly interfere with its usefulness. It consists of Bismuth Sub-nitrate and Rochelle salt dissolved in solution of Soda or Potassa. As usually made it differs somewhat from the original formula devised by \*Nylander, and is thus prepared: Two parts of Bismuth Sub-nitrate, and four parts of Rochelle salt are digested in 100 parts of a ten per cent solution of Potassa until dissolved. It seems to keep well, which is a great advantage over Fehling's solution.

When boiled with saccharine urine a black precipitate occurs as an indication of the presence of the sugar. The fact that the test-liquid is colorless instead of blue, and that the precipitate is black instead of yellow, tends to increase its delicacy, for a black precipitate in a colorless liquid is much more readily seen than a yellowish precipitate masked by an opaque greenish or bluish fluid.

According to my experience, neither \*Nylander nor †Penzoldt give the most advantageous proportions in which to use this solution. They direct more of the test solution to be used than of the urine to be tested. I have found that when the proportion is reversed, and more urine than solution used, the reaction becomes more marked.

The operator should mix one part of the test solution with from three to four parts of the suspected urine; it is more convenient to use enough of both to more than half fill the test tube. Heat is now applied to the upper half of the liquid only. If there is no sugar present, the heated portion will exhibit a white turbidity, a part of which will, on standing, fall rather rapidly to the bottom, but will not change color. If sugar is present in any quantity, the same phenomena will occur, but the precipitate will be black.

Any one can prove for himself that this test is somewhat more delicate than Fehling's, by diluting saccharine urine

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\* Zeitschrift für Physiol. Chem. viii, 175.

† Aeltere und Neuere Hamproben, Jena, 1886.

with normal urine until a point is reached where Fehling's test shows a bluish-green turbidity, but no characteristic precipitate that is to a point slightly beyond its reach. With such urine Nylander's test will still give a precipitate distinctly darker than with normal urine. The lack of certainty spoken of only occurs in urine containing an organic sulphur compound, such as Albumen or Cysten. As albumen can readily be excluded, and other sulphur compounds are very rare, these sources of error are not of great weight.

The Picric acid test is performed by adding a small quantity of a saturated solution of Picric acid to the urine, then a few drops of Solution of Potassa, and heating. A deep red color indicates sugar. This test is to be commended for the great ease with which it is performed, but not for its reliability. The fact that Solution of Potassa with urine containing Picric acid already gives a similar darker color, without sugar being present, shows that the judgment must be based upon the depth of tint. Urine containing an amount of sugar quite within the sensitiveness of Fehling's test, gives no distinct difference with this test from entirely non-saccharine urine. We now come to a test which combines the advantages of absolute certainty, of great delicacy if rightly carried out, and of being an approximate quantitative test.

On the other hand it requires time and a special apparatus. This is the fermentation test. Two or three fermentation tubes are necessary. A piece of compressed yeast about the size of a small pea is shaken up with 10 c. c. of urine, and poured into a fermentation tube in such a manner that the upright portion is completely full, with no bubbles of air at the top. It is then set in a warm place. Fermentation begins, if sugar is present, in a short time, and the carbonic acid gas formed collects in the upper portion of the tube, the displaced liquid gradually going into the bulbous part. When the action ceases, the height of the liquid is read off by the graduations on the tube, which are both in per cent and cubic centimeters.

As yeast sometimes gives off a little gas that is either pressed into it or generated from a minute amount of sugar, it is always advisable, when the quality is not known, to mix a similar portion of it with 10 c. c. of water, and pour into another tube, which is allowed to stand with the first. The amount of gas, if any, given off from the yeast alone, would have to be deducted from the other result. Some advise a third tube, containing a sugar solution and yeast, to prove the effectiveness of the yeast. This is entirely

unnecessary if a good compressed yeast is used. Fleischman's, sold at every grocery, has never failed me, and gives off so little gas that even the second tube seems a useless precaution.

Greater accuracy can be attained by making the fermentation tube longer and more slender. Those usually sold are graduated from one-quarter to one per cent only, so that if the urine is suspected, from a preliminary test, to contain more than one per cent of sugar, it should be diluted with a known amount of water, and the water allowed for in making the calculation.

I have never known nor heard that this test failed or gave an erroneous result, yet I can *conceive* of a condition where a gas might be given off without sugar being present; namely, in a specimen containing much mucus, under the influence of warmth, rapid decomposition might take place, and a limited amount of gaseous ammonia might collect in the tube from this cause. With this single exception, which, as far as I know, has never happened, the result may be regarded as absolutely reliable.

In conclusion, we may regard Trommer's and the Picric acid test with suspicion, but accord a high degree of excellence to both Fehling's and Nylander's solutions, either of which, however, would have to yield, in doubtful cases, to the verdict of fermentation.

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## Commencement Exercises

OF THE HAHNEMANN MEDICAL COLLEGE AND  
HOSPITAL—SESSION 1888-89.

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The Twenty-ninth Annual Commencement Exercises of this medical school and hospital were held in the Grand Opera House, Chicago, at 2 p. m. on Thursday, February 21, 1889. The beautiful building was filled with a large audience of the friends of the institution, and of the graduating class. The exercises, which were enlivened by the most delightful music, were opened with prayer, after which came the reading of

### THE ANNUAL REPORT,

BY PROF. E. S. BAILEY, M. D., REGISTRAR.

*Mr. President* :—In a few moments the last words of the twenty-ninth annual course of lectures in the Hahnemann Medical College and Hospital of Chicago will have been spoken, and the session will be ended. As a part of the closing exercises of the Commencement Day the faculty bids me say to the honorable Board of Trustees, and to the friends of the institution, that earnestness and enthusiasm on the part of both teacher and pupil have been manifest throughout the entire session. The college and hospital appointments have been righteously kept, and in reviewing the work of many months we are glad to report that the year has been marked by continued prosperity, and with the added experience of the teachers, and the constant strife to keep pace with the progress of the times, better instruction has been the result.

During the winter six hundred and forty didactic lectures have been given; one hundred and sixty-eight clinical lectures, or clinics, have been held; and, in the sub-clinic work, one hundred and ten hours have been devoted to special instruction, making for the labor of this session

more than one thousand lecture hours of didactic and object-teaching. The presentation of these figures in no way gives expression to the efforts on the part of the teaching corps to present as accurately, concisely and forcibly as possible the truths pertaining to the science and art of healing, to advance in every way the best interests of the students, to keep in exact harmony with the demands of a progressive and intelligent profession, and to comply literally with all of the legal requirements of this and other States.

The lecture course has been attended by *two hundred and twelve* students, of which fifty-one are women and one hundred and sixty-one are men. As in years gone by, many of the students have sought this college from the remote portions of our own and foreign countries. This year the representatives came from the Northwest Territory and Canada, from Florida and Texas, and Mexico, and from Maine to the Pacific.

Never was a faculty accorded better attention, more respectful, diligent, earnest and hearty cooperation than that rendered by the members of the present class. We can report nothing but an anxiety on the part of the students to acquire the kind of knowledge that would best fit them for their chosen vocation, and right royally and loyally has each and every one labored for this great end. We can also speak with pride of the favorable progress and success of the liberal opinions and methods of this college respecting co-education, and the lifting up, and faithfully adhering to the demands of a higher grade of medical education.

In the parting word we can not add to or take from the serious, earnest and thoughtful words of the lecture course. We only say, in your professional life be brave and be compassionate.

Of those who, having complied with every requirement of this college, and also of the State Board of Health, have been found worthy, after a final and plenary examination, seventy-eight candidates are herewith presented for the degree which, Mr. President, it is your pleasant duty and privilege to bestow.

**THE CONFERRING OF THE DEGREE.**

BY DAVID S. SMITH, M. D., PRESIDENT.

The members of the graduating class, having been stationed in sections, one after another, upon the stage, the President of the Board of Trustees, Dr. D. S. Smith, conferred the degree of Doctor in Medicine and Surgery upon each and all of the *seventy-eight* candidates recommended by the Faculty. This pleasing ceremony closed with a few earnest and eloquent words of encouragement and of welcome to the young doctors, which neither they nor the audience are likely soon to forget. The following is

## A LIST OF THE GRADUATES.

AMES, JAMES GRANT,	. . . . .	Ohio.
BACKHOUSE, ANNIE A.,	. . . . .	Ontario.
BAKER, AMBROSE E.,	. . . . .	Massachusetts.
BARFUS, OSCAR EMIL,	. . . . .	Pennsylvania.
BARIGHT, JULIA STRINGHAM,	. . . . .	New York.
BEACH, JOSEPH P.,	. . . . .	Wisconsin.
BECKER, ARP,	. . . . .	Illinois.
BOICE, JOHN M., <i>ad eundem</i> ,	. . . . .	Ohio.
BOWER, ERNEST C.,	. . . . .	Illinois.
BOYCE, HOMER P.,	. . . . .	Illinois.
BROWN, MARCUS SIMEON,	. . . . .	New York.
BUSENBARK, LUCY M.,	. . . . .	Iowa.
CALDWELL, T. ADDISON, <i>ad eundem</i> ,	. . . . .	Illinois.
CHAMBERLAIN, ANDREW J.,	. . . . .	Wisconsin.
CLARK, NANNIE C.,	. . . . .	Illinois.
CLAYSON, JULIA GREGG,	. . . . .	Illinois.
CLEMENT, WEBSTER JOHN,	. . . . .	Wisconsin.
COCHRANE, T. CLARENDON,	. . . . .	Maine.
COLLINS, CLINTON DEWITT,	. . . . .	Wisconsin.
DANFORTH, MRS. MARY,	. . . . .	Michigan.
DUNHAM, HENRY E.,	. . . . .	Iowa.
DURIN, JAMES MILTON,	. . . . .	Illinois.
FAULKNER, ELMER ELLSWORTH,	. . . . .	Nebraska.

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FINNERUD, HANS. M., . . . .	Minnesota.
FOWLER, ADA A., . . . .	Indiana.
GATES, G. HEBER, . . . .	Wisconsin.
GILLARD, CLARA HYDE, . . . .	Ohio.
GORDON, SARAH ANNA, . . . .	Missouri.
HALL, AMOS C., JR., . . . .	Indiana.
HANNA, WILLIAM BLAKEWAY, . . . .	Iowa.
HILL, MARK A., . . . .	Illinois.
HILL, RAY G., . . . .	Kansas.
HOEY, WILLIAM FERGUSON, . . . .	Delaware.
HOCKETT, OLIVER O., . . . .	Illinois.
HOLMES, LOUIS C., . . . .	Nebraska.
HOYT, LUCIUS FRANK, . . . .	Minnesota.
HUNTSINGER, CHAUNCEY, . . . .	Indiana.
JACOBS, WILLIAM H., . . . .	Delaware.
JUNKERMANN, CHARLES F., . . . .	Ohio.
LAROCHE, PIERRE, . . . .	New York.
LINN, ELLIS G., . . . .	Iowa.
LOVE, GEORGE FRANKLIN, . . . .	Michigan.
MALOY, ALFRED J., . . . .	Illinois.
MCDOWELL, GEORGE W., . . . .	Illinois.
McKNIGHT, GEORGE B., . . . .	Wisconsin.
MENNINGER, CHARLES F., . . . .	Kansas.
MERRIMAN, CHARLES WEARE, . . . .	Wisconsin.
MORRIS, ROBERT NELSON, . . . .	Michigan.
MOSIER, WILLIAM A., . . . .	Indiana.
MUSGRAVE, SYLVESTER DAVIS, . . . .	Indiana.
OLIVER, THOMAS H., . . . .	Ohio.
PARKER, HELEN M., . . . .	Illinois.
PAUL, C. ALMON, . . . .	Maine.
PECK, MARY E., . . . .	New York.
PECKARDT, KATE E., <i>ad eundem</i> , . . . .	Illinois.
PERKINS, ARCHIE ELMER, . . . .	Massachusetts.
RIDGWAY, MINNIE, . . . .	Illinois.

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ROBERTSON, HELEN M., MRS.	New York.
RIVERS, THERESA KRAUTER,	Illinois.
RUSSELL, WALTER E.,	Wash. Territory.
SEVERANCE, KARL JEROME,	New York.
SHIMER, CHESTER S., <i>ad eundem</i> ,	New York.
SMALL, J. WINFIELD,	Michigan.
SPEERS, M. ELIZABETH,	Iowa.
STAGGS, WILLIAM ANDREW,	Iowa.
STARR, NATHAN,	Illinois.
STEWART, JOHN W. G.,	Indiana.
STORER, JOHN,	Illinois.
THATCHER, HAINES C.,	New York.
TRUITT, WILLIAM JOHN,	Delaware.
VAUGHAN, ELMER E.,	Vermont.
VOLLMAR, J. CASPAR,	Michigan.
WATSON, WILLIAM W.,	Michigan.
WEBSTER, JUDSON T.,	Wisconsin.
WELCH, WILLIAM ROBERT,	Kansas.
WEST, ISAAC C.,	Texas.
WHELAN, MARTHA,	Washington, D.C.
YOUNG, ANNIE M.,	Illinois.

### VALEDICTORY ADDRESS.

BY REV. C. G. TRUSDELL, D. D.

It is the unexpected that comes to pass. The law of compensation finds an illustration in the circumstances of the hour. I have occasionally been compelled to take your medicine, but never expected to have the privilege of returning the compliment by giving you some of mine. I hope that it will not be construed as unfriendly to your system if mine should be a larger dose and a lower attenuation than you are accustomed to prescribe. Allowance must be made for the natural excitement of the first call, as well as the quality of the patient. If mine shall prove only half as palatable and beneficial in its results as I have always found yours to be, I shall be as happy as you are when, after much anxiety and careful nursing, you have brought a desperate case to convalescence.

I will not take advantage of your position to preach to you, nor yield to the temptation to glorify your profession; nor will I attempt to paint an elaborate picture of the wide and beautiful prospects before this splendid graduating class of Ladies and Gentlemen. In their imagination they have doubtless already explored these fields, and strewn them with flowers, and peopled them with fairies in the shape of patients anxiously awaiting their advent, ready to pour their golden treasures at their feet. "Taffy" is a very good thing in its place, and, as a friend of mine recently expressed it, a little "taffy" now and then, while we are alive and can enjoy it, is better than a good deal of epitaphy when it can do us neither good nor harm.

A simple change of diet is sometimes a good medicine. If I may turn your thoughts from the rich and abundant material upon which you have been accustomed to feed during the years of your college life, to a few practical suggestions not usually embraced in the college curriculum, it may give you a rest, and so improve your mental digestion.

I announce as my theme: *The Elements of True Success in Life, and How to Win It.* No curriculum of the schools furnishes a complete equipment for the work of life in any profession. The most that any of them can do in the few years that are spent in the college or university is to furnish them with a few tools and teach them how to use them. Ministers can not be turned out full-fledged from theological institutes, nor physicians from lecture rooms and dispensaries. Soldiers can not be made in barracks, nor seamen in navy-yards. The best and all that these can do is to give general instruction and a few illustrations. The drill and arms are indispensable as a preparation, but until these are tested in actual service they are of little value. Their use and usefulness must be proved by contact with the enemy. The most valiant are at a disadvantage without them. The best armed are equally at a disadvantage if they know not how to use them. In the hands of ignorance and inexperience sometimes the best of weapons are more dangerous to the holder than to his antagonist.

The great world, with its *opportunities, responsibilities* and *opposition*, is the field for testing and achieving. The storm-tossed vessel upon the trackless ocean, amid the darkness and the tempest, the long and weary vigils, the exposure to the elements, the perils and hardships of deck and fore-castle, are what make sailors. The weary march through mud and sleet, the hand-to-hand conflict on stubbornly contested fields, familiarity with scenes of suffering and death, the thrill of victory and the humiliation

of occasional defeat, are the experiences out of which heroes and veterans are made. The disappointments and persecutions; the jealousies and misrepresentations of ignorance and prejudice; the sneers of bigotry and malice; the protracted struggle for recognition; the patient plodding, working, hoping, and suffering—these are the things to be encountered and conquered in order to achieve real success in life. Only by this discipline and drubbing can the average man become transformed into the skilled mariner, the invincible chieftain, the accomplished scholar, the sturdy reformer, or eminence and power be reached in any sphere or profession. You are not likely to suffer for want of these in your chosen profession, as you will discover ere long, not to your cost so much, but to your advantage, if you have the wisdom to appreciate them at their true value, and the power to transmute them by the alchemy of *work* and *patience* into the purest gold. The diplomas just distributed merely certify that those who have known you long and well have started you on the right track, and have faith in you that you will push ahead and keep ahead, in spite of everything that allures or threatens, until you have gained your place of power and usefulness, and can maintain it against the world.

All success implies *progress*, and the *measure* of progress in any proper direction is the measure of success. All real progress is greatly facilitated by as thorough preparation as possible; but no progress or success is complete or finished while there is anything beyond. Each conquest or achievement nerves the arm and whets the appetite for more. All achievement is but the preparation and incentive to greater effort and further advancement. To such a faith and ambition there is no limit in this life, and if inspired by love of truth there will be no limit in the life to come. Men may attend lectures by the most eminent professors, year after year, in all the colleges and universities in America and Europe; they may spend years in hospitals, until they have become familiar with every symptom and shade of all the diseases that human flesh is heir to; they may be experts at carving, able to locate and describe the relation and function of every nerve and muscle in the human body; they may be able to analyze and combine, and go through all the stock experiments of the laboratory, and invent new ones for the display of their marvellous knowledge of chemistry, and their power over nature, to the amazement of the uninitiated; they may decorate their walls with diplomas, and exhaust the alphabet for letters to represent their titles; they may be able to write their prescriptions in every known and unknown tongue, and yet be destitute of

those qualifications which are necessary to the truest, highest and most enduring success in life.

What is true of one profession, or department in life, is true of all. There are certain things that are fundamental, and indispensable. In order to the truest success in life there is something more than intellectual culture, or mental furnishing; more than professional skill and experience; more than recognition and endorsement; more than reputation and position. Something that lies back of these; that begins at the very root of things and runs parallel with all the lines of life; things which constitute the only foundation upon which a truly successful career can be constructed. When this obtains, then all materials may be employed in the superstructure, and find some appropriate place in the building, contributing to its utility and beauty, but without which all else, however costly and beautiful to the eye, is but as cornice and fresco, as gilding and varnish, to the granite that is alone suitable for foundations, and that has the power and endurance to stand out from every story to confront the elements and to defy the ravages of time.

This foundation in every man's life-building is character, and the appropriate material out of which it is to be constructed is truth. It is a universal and eternal law of nature, as well as of religion, that "every man is the architect of his own fortune," and that fortune consists in character *versus* circumstances or professions. The love and pursuit of truth, which is the natural aliment of the mind, is the condition and measure of intellectual progress, and the universally recognized and approved standard of character. This is not so because the preacher says so, or because it is found in any book of science, history or morals, but because of the natural constitution of things and the universal sense of mankind. We sometimes select from the multitude a conspicuous man and label him "self-made." All men are self-made. They are what they have made themselves, and they have made themselves what they are. And all men can make themselves what they will. Other things equal, due allowance being made for circumstances, as heredity and environment, there need be little qualification to this rule. Man is to some extent the creature of circumstances, but as a rule he need not be unless he chooses to accept the circumstances, and then he deliberately resigns himself to them, and becomes their slave, not from necessity but from choice. Man was made to govern circumstances. He is undoubtedly more or less under the general influence of heredity, but not so as to control his character against his will. He is influenced more or less by environ-



ment, but he has the power to change and choose his surroundings. He can accept the circumstances and conditions in which he finds himself and settle down to passive existence, or he can rise to place and power, and influence among his fellow-men, in spite of all circumstances and surroundings, if he has the sense and the pluck. If at the foundation he has character, a correct moral sense, with faith in God and in himself, and the sense to understand that he has all the helps that any man can use if he will but assert that which is in him, and which is lying all about him ready to be utilized and incorporated into tools and capital, he can force all circumstances into his service.

Recently in representing a successful business man who had come up within a few years from an obscure, friendless and penniless lad to prominence and influence as a capitalist and merchant, a gentleman said of him as representing the elements of his success that, "he had one pair of hands and an opportunity." He ought to have added "and the sense to see, and the courage to seize the opportunity." "Know thyself," was the favorite maxim of the old philosophers, esteemed of sufficient value to be emblazoned in golden capitals upon their temples, to which they added another, viz.: "Know thy opportunity;" to which we would add a third, viz.: "Know thy fellow-man." Not only the physical constitution, the wants and weaknesses, but the mental and moral, the social and political powers, and rights and claims of our fellow-men, and knowing, respect and defend them as our own.

To no class of men is this knowledge more important than to physicians. Many diseases originate in mental and moral disturbance. Cures in many instances must come in the subtle and mysterious realm of the intellect, and the conscience. In order properly to diagnose the case and to reach the seat of the disease with appropriate remedies, the physician must be both philosopher and Christian. I am no "Metaphysician," or "Christian Scientist." I have no respect whatever for the theory or practice of these fanatics, to use the mildest term that to my mind describes them. No doubt there is a good deal that is plausible, and some things that are certainly true in their pretensions, which is not original with them nor exclusively theirs. It is no new thing, or unknown to all schools of medicine, that some diseases are purely imaginary; that the mind exerts a powerful influence upon the body—that the spiritual affects the mental and physical, and *vice versa*.

I have taken pains to investigate to some extent the philosophy of this craze, if there is any philosophy in it. I have read several of the most popular works by the leading

authors and advocates of these systems, and to me they seem to be a strange hodge-podge, or conglomeration of Bible, Koran, Buddha, Shakspeare, the Book of Mormon, Socrates, Carlyle, Browning, Cora Hatch and Col. Ingersoll; a mixture of Orthodox Christianity, Heathen Mythology, Oriental Philosophy and Poor Richard. They read, as we might imagine the writings of one who had read more or less of all these authors and systems, and after getting them all jumbled up in their minds had without any order, sense, or reason, poured them forth in a medley of superstition and enthusiasm. They are simply a string of proverbs, maxims, moral precepts, recipes and scientific allusions, with quotations from proverbial philosophy, calculated to bewilder and mystify the ignorant and the credulous, while it can hardly fail to disgust the candid and practical mind. With all that, and quite independent of that, and no thanks to them for the discovery, it has been well understood in all ages and by all physicians, that many ailments, real or imaginary are the result of a disordered mind, and that they can be successfully treated or dispelled only by one well-skilled in all of the idiosyncrasies and hallucinations to which the mind of man is subject.

Medical Science deals with the whole being and nature of man, and must, therefore, take cognizance not only of the physical, but of the mental and spiritual. The physician, therefore, should be a person of the broadest culture, the warmest sympathy, the clearest insight into human nature, and a living illustration of Truth. The present age is preëminently the conflict period; and our country is the battle-ground between Truth and Error, between facts and theories, between mythology and reality. Men are everywhere in all departments of science, philosophy, government and religion, breaking away from the old tyranny of authority and superstition, and demanding and exercising the right to think for themselves. This struggle has been going on with more or less vigor, and with varying success from the earliest times, but was never more general or determined than at present.

What is Truth? is the great question of all the ages, to which a full and satisfactory answer has never been given. Many have claimed to discover it, and to hold a monopoly of it, while others, equally wise and much more honest, doubt if anything can be certainly known.

One of the old philosophers plaintively exclaims: "*Nothing can be known; nothing can be learned; nothing can be certain; sense is limited; intellect is weak; life is short.*" Another tells us that "It is impossible to be cer-

tain of anything; that we can not even know positively that we know nothing." This last finds few professed adherents, but many living illustrations in our land and time. Much of the glorious results of this conflict, and the prophecy of the ultimate triumph of Truth is seen in our own country, in our free schools, free press, free speech, and free pulpit. The idea that ruled the world for thousands of years—though never without protest—was that man was made for government; that religion was faith in creeds; that science belonged to astrologers and magicians; that politics was the exclusive property of office-holders; that the people were so many voting cattle, to be whipped into the political traces by the party-lash in the hands of bosses who fattened upon the spoils, or, that they were to be mustered into armies to fight the battles of ambitious and unscrupulous Emperors and Kings. In harmony with these views, to question the divine right of kings was treason, to be punished with confiscation or the block; to claim the right of conscience and private interpretation as against the dogmas of the church was heresy, which was to be exterminated by the inquisition.

The two hoary monsters, Age and Power, like great Cyclops, stood on either side of the path of human progress threatening to devour any bold seeker after truth, who ventured to pass beyond the territory that they had usurped, in order to explore the fair fields of Truth that lay beyond. All this is changed, at least in so far as this country is concerned, and largely, too, throughout the civilized world. The proclamation of emancipation has gone forth in many lands, and there has come to be recognized the dignity and rights of man as man; that governments, in the language of our own immortal Lincoln, "*are of, and for, and by the people,*" that rulers hold their places and exercise their powers within prescribed limits, and for the benefit of the public; that the same power that made them can unmake them whenever they become unworthy or incapable of being trusted with public interests; that the church has authority over faith, only so far as its doctrines and practices are approved by conscience and reason; that politics is the greatest good to the greatest number, and that Truth and Liberty, Opportunity and Protection are the natural and inalienable rights of all men, irrespective of creed, race or color; that the doors of learning, wealth, power and prominence are thrown wide open to all seekers after these treasures; that *Character* is the only title of nobility and passport to eminence; that intelligence and morality are the standards of character, and that usefulness and blessing to others is the real measure of success in life.

If these things are so, they must reverse and correct some popular errors that have too generally obtained, as that success is to be measured by *social position*. Nothing is more tempting to those starting out in the great work of life, and nothing more false, than to suppose that success depends upon social position or influence. Society seldom courts or bestows her smiles upon a man until he has lifted himself into a position to be courted. By that time he is independent of her favors, and the less he responds to her coquettish airs the better it is for him. Most men of experience understand that the best paying business, the truest friends, and the greatest fields for usefulness are in the middle walks of life and among the comparatively poor.

Others make *wealth* their standard of success. It would be folly to deny that it has advantages, and is not by any means to be despised. Those who are fortunate enough to acquire it by legitimate enterprise have the right to enjoy it, and are not to be denounced. When coupled with or controlled by intelligence, liberality and patriotism, it is a great source of blessing to its possessor and to the public. To it we are indebted for the endowment of institutions of learning, for the founding of great public libraries, for the promotion of art, for the support of hospitals and asylums, for the carrying forward of great manufacturing and commercial interests, for many public improvements, and for the development of inventions which furnish employment for the millions, and place enjoyment and culture within the reach of all. Wealth is to be deprecated only when it is hoarded, or cast into golden calves before which its stupid worshipers prostrate themselves, and the man shrivels and shrinks until he is lost and swallowed up in the calf.

*Fame* is another standard adopted by some. She is a fickle goddess, seldom if ever captured by those who woo her, while few who are worthy of her escape her embrace, whether they will or no. It will not pay to run after her, but if one has ever done anything to make him famous, it will be safe to leave his interests in her hands. If posterity thinks a man worthy of a monument, it will build it, and put things upon it that would make him blush to read. Whether they do or not matters little to those who pass the monument period. Titian says: "Be true to yourself and fame will be true to you."

Shall we speak of *Power*? This is a dangerous possession, and ruins more than it blesses. Few attain it, and most of these are happier when they relinquish it. All covet it, though they know that it excites the envy of all beneath them, and that its most obsequious sycophants would

hail with pleasure the opportunity to seize its sceptre, despoil it of its crown and robes, and demolish its throne in order to erect one for themselves upon its ruins, and in order that they may have the same experience.

Or *Pleasure*? This is the object of pursuit and standard of success with many, because it requires neither character nor brains. It is the most deceitful of all; promising much, it gives but little, and by its own force exhausts the capacity to enjoy anything but the excitement which soon kills both soul and body.

All these common objects of pursuit and popular standards of success in life are false and fickle. *Truth* is the only thing that abides and never disappoints. It is the root from which all things valuable and desirable grow. Truth is the tree of life, in the midst of the garden, whose fruit is beautiful to the eye, delightful to the taste, much to be desired to make one wise, and its leaves are for the healing of the nations. Truth is the chain let down from heaven, whose first link is fastened to the throne of God, and coming down through the infinite spaces beyond the stars to our planet, encircles the earth. Get possession of but one of these links and it leads to another, and another, and another, until, if followed in all its connections and relations, it leads us into all Truth. The measure of its attainment and conformity to its requirements, that is character, and character built upon Truth is *Success*. To know this Truth, and to hold it in sincerity and with consistency, is to be upon the high road to eminence and power; and nothing worthy of the name of success can be reached by any other route.

I give you as my parting prescription these two ingredients, which, if well mixed and constantly taken, will inevitably lead to success on the above line, viz: *Work* and *Wait*. Other things being equal, he who, having chosen his life-work in harmony with the foregoing suggestions, and can work most persistently in the right direction, never suffering himself to be discouraged or diverted from it, will not toil in vain, nor spend his strength for naught; and if he can add to that the crowning virtue of patience to wait, success will come, nor will it be long delayed. Work develops and increases strength, while patience nerves the brain and heart and hand for greater endurance, and so makes achievement sure and easy. These are the qualities that make men. The great men of every age have been illustrations of this truth. If I should catalogue the great scholars, statesmen, poets, physicians, lawyers, ministers, authors and artists whose lives have blessed humanity and whose achievements have enriched the world, you would

find that at the base was Character formed on Truth, as they were permitted to see it; that the love of Truth was the inspiration of their lives; and that, in its pursuit, their joy and triumph was to WORK and WAIT.

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*THE PRESENTATION OF PRIZES, ETC.*

Only two prizes were offered and awarded, at the hand of Prof. Vilas:

That for the best general examination in all the branches, the D. S. Smith prize of \$50, was given to NATHAN STARR, of Paris, Ill.; and

That of \$25, in gold, for the second best general examination, was taken by ARCHIE ELMER PERKINS, of Massachusetts.

Honorable mention for excellence in the final examination was made of Charles F. Menninger, of Kansas; Chas. W. Merriman, of Wisconsin; Wm. B. Hanna, of Iowa; Oliver O. Hockett, of Illinois; Ellis G. Linn, of Iowa; Homer P. Boyce, of Illinois; James Grant Ames, of Ohio; E. E. Faulkner, of Nebraska; Wm. E. Truitt, of Delaware; and Clara Gillard, of Ohio.

The appointments for the Hahnemann Hospital, for the ensuing year, were as follows:

For House Physician—WILLIAM B. HANNA, M. D., of Iowa.

For House Surgeon—WILLIAM F. HOEY, M. D., of Delaware.

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*THE RECEPTION AND BANQUET.*

The Commencement Season closed with the usual Alumni Reception and Banquet, which was held in the Sherman House on the evening of February 21. The President, Dr. D. S. Smith, occupied the chair. Profs. Shears and Hoyne were the efficient Committee of Arrangements, and Prof. Hawkes was Toast-master. The company consisted of the members of the Board of Trustees, the Faculty, a choice lot of the old Alumni, the new class of graduates, and a host of ladies and gentlemen, all of whom entered heartily into the good feeling and fellowship of the occasion.

In the full recollection of all the enjoyable gatherings of the kind which have been held within the last thirty years, less one, this reception may be declared the most delightful and satisfactory. The responses to the toasts by the jolly and loyal old President, Mr. MacFarlane, of the Board of Trustees, and Profs. Vilas, Leavitt, Shears, Gilman and Crawford, Dr. F. W. Gordon, on behalf of the old Alumni, and Dr. C. W. Merriman, of the graduating class, were of the most happy and hearty description. So that the round-up and the break-up of the Annual Winter Session in the old Hahnemann was in keeping and in touch with its best chronicles, and with the best wishes of its hosts of friends everywhere.

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#### THE ALUMNI ASSOCIATION MEETING.

The sixth annual meeting of the Alumni Association of the Hahnemann Medical College and Hospital, of Chicago, was held in the club-room of the Sherman House, on the evening of February 20, Dr. C. H. Vilas in the chair. The large room was crowded to overflowing with the old and new graduates of the school, and the occasion was very enjoyable. The routine reports of the Secretary, the Treasurer and the Necrologist were presented, after which the usual "love-feast" was held. Brief speeches were made by the older and the younger members, and the college days were lived over again in a very pleasant way. The committee on the hospital reported progress, and the question of building and endowing such an institution was seriously considered. The officers chosen for the coming year were: *President*, Dr. F. W. Gordon, of Sterling, Ill.; *First Vice-President*, Dr. E. E. Gwynne, of Chicago, Ill.; *Second Vice-President*, Dr. G. D. Bushee, of Englewood, Ill.; *Secretary*, Dr. R. Ludlam, Jr.; *Treasurer*, Dr. J. P. Cobb, Chicago; *Necrologist*, Dr. E. S. Bailey; *Executive Committee*, Drs. G. F. Shears, N. C. Kemp and C. Missick.

## Hospital Notes.

### THE WOMEN'S CLINIC.

#### SERVICE OF PROFS. LUDLAM AND BAILEY.

At the closing clinic of the Winter Session, February 20, Prof. Ludlam took occasion to remind the class of the superior advantages that they had enjoyed in this particular department. The figures given were as follows:

In Gynecological Surgery he had held twenty-eight regular clinics in the amphitheater before the whole class, and eighteen sub-clinics with operations before classes of twenty Senior students. During the same period Prof. Bailey had conducted twenty-six sub-clinics for the benefit of the Seniors, and had also had eight general clinics on the Medical Diseases of Women. This showed a yield of *eighty* clinics, making an average of *four* clinics each *week*, with an abundance of excellent material during the whole twenty weeks of the term.

Among the interesting cases that had been studied in the clinics on gynecological surgery were two cases of tuberculous peritonitis, upon one of which Prof. L. had made a laparotomy. One of extra uterine pregnancy, with the specimen; one cervical fibro-myoma; several each of procedentia uteri, cystocele, hystero-epilepsy, uterine fibroid and cancer, ovarian tumors, fistulæ and lacerations of the perineum and cervix. The class had witnessed six laparotomies—two by Prof. Bailey and four by himself; one was the Battey-Tait operation; one for cysto-sarcoma of the ovary; one extra-uterine fibroid removed during pregnancy; one Polk's operation for adherent appendages; one for unilocular ovarian cyst, and one for a fatal case of hæmorrhagic peritonitis; the total result being five recoveries and one death.

If we add to the above the thirty-two didactic lectures given meanwhile by Prof. Bailey, we have a total of 112 clinics and lectures for this single department during the term just closed.



## Miscellaneous Items.

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The Post-Graduate course opened February 26, with a class of 68.—The photographic group of the members of the American Institute of Homœopathy, furnishes excellent portraits of about 1,100 of the best-looking doctors extant, and reflects great credit upon our indefatigable friend, Dr. T. Franklin Smith, of New York, who has arranged and published it.—The Homœopathic physicians of South-Western Wisconsin have organized a Clinical Association, with Dr. L. S. Ingman, of Madison, President; Dr. W. P. Roberts, of Evansville, Vice-President; and Dr. Delia G. Main, of Madison, Secretary.—Dr. H. N. Lyons' article on "The Urine in Bright's Disease," the second part of Dr. W. F. Robinson's translation of Hegar's "Reflex Uterine Neuroses," and the report of Dr. Belle Reynolds' rare case of brain disease, will appear in our next issue.—Our Clinical Reviews are unfortunately crowded out, but they will keep.—Dr. Alfred C. Pope has removed from Tunbridge Wells to Watergate House, Grantham, Lincolnshire, England.—Our thanks are due to Dr. Jas. H. Thompson, of Pittsburg, for the notes of a case of suprapubic lithotomy, which we shall find space for next month.—If any of our readers have had an experience akin to Dr. Poppe's, reported at the last meeting of the Clinical Society and published in this number, we would be glad to have the facts.—In answer to a political "whopper" that some of our journals have published concerning the extravagant expenses of the Illinois State Board of Health, the following from Gov. Oglesby's message January 9, 1889, is a sufficient reply: "That the Board has been prudent and economical in the expenditure of appropriations subject to its order, is manifest from the fact that the contingent sum of \$40,000 for 1885-86 was conveyed back into the Treasury untouched. Of a similar amount appropriated for 1887-88, only a small amount has been expended. I recommend the usual appropriations to sustain the Board, and continue its usefulness to the State; and have no doubt that it will be wise to continue the usual contingent appropriation."

# THE CLINIQUE.

Vol. X.]

CHICAGO, APRIL 15, 1889.

[No. 4.

## Original Lectures.

### *VARICOCELE.*

A CLINICAL LECTURE DELIVERED AT THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO, BY PROF. G. F. SHEARS.

The first patient I have to present to you to-day is afflicted with a very common disease known as varicocele. By this term is understood a dilated and tortuous condition of the spermatic veins. I have called this condition a disease because it certainly is a deviation from the normal, yet it is in so many cases unattended by pain or inconvenience that writers like Sir Astley Cooper and Sir James Paget declare that it hardly deserves the name of a disease. There are, however, some instances in which the pain is excessive, and many others in which the very presence of the trouble occasions so much mental distress that it becomes a matter of serious moment and deserves the careful consideration of the surgeon.

The disease usually arises soon after puberty and is most common between the ages of fifteen and thirty-five. It is said that of two million men examined for admission into continental armies ten per cent had varicocele. A peculiarity of the trouble is the uniformity with which it affects the left side, a varicocele of the right being extremely rare. I do not now remember of ever having seen a

varicocele of the right side alone, although I have seen several cases of double varicocele. In these cases I may say there was also a varicose condition of the lower extremities. This partiality for the left side has been explained as due to the fact that the left vein is longer than the right and has a heavier column of blood to support; that its direction is more at a right angle to the current of blood; that the left from its position is more liable to be pressed upon by a loaded colon; that the right spermatic vein has valves at its entrance into the vena cava, but that the left is unprovided with valves at its junction with the renal vein. These and other reasons have been given for its presence on the left side, the inference being that it is a disease which makes its appearance during sexual life as a result of a disturbed condition of the circulation due to constipation, venereal excess or other irritation. I am rather inclined to look upon it as a congenital deformity that is not noticed before puberty because these parts being nondeveloped prior to that change do not demand a large supply of blood.

In this connection it is interesting to read the list of disorders which Dr. Henry Duchene has enumerated as especially affecting the left half of the body. He says obliterating arteritis affects the left Sylvian artery oftener. Tubercle affects the left lung oftener; calculous nephritis and renal cysts the left kidney; orchitis the left testicle; ovaritis the left ovary; varicocele the left spermatic vein; neuralgia, chorea, hysterical anaesthesia the left side; cancer of the breast the left mamma.

Whatever the cause, the disease is slow in progress and usually attains some size before it occasions any inconvenience. The earliest symptom is a sense of weight and uneasiness in the testicle which feeling often extends up the cord to the groin and to the back. This is aggravated by standing or great exertion. A sharp neuralgic pain sometimes takes the place of the ordinary uneasiness. The scrotum of the affected side is flaccid, pendulous and subject to profuse perspiration. The most prominent symp-

tom is the enlarged and dilated veins. These can sometimes be seen and always readily felt as an elongated, conical shaped enlargement, irregular and compressible like a bundle of cords or a bunch of earthworms. Very few of you, I think, would mistake it for any other affection, and yet to my certain knowledge it has been mistaken for both hernia and hydrocele. With the former when reducible it has these symptoms in common: disappearance upon lying down, increase in standing, and impulse on coughing. It differs from it in feel and particularly upon applying the following test: Place the patient in the recumbent posture and hold the scrotum up until empty then make firm pressure upon the external ring, and with the pressure maintained have the patient take the erect posture. If a hernia the enlargement will not appear, if a varicocele the veins promptly fill and the enlargement returns. In common with congenital hydrocele it returns upon lying down, increases on standing, and has a slight impulse on coughing, but the hydrocele is firm on pressure, fluctuates and is translucent, so that with care no mistake may be made.

In this case the tumor responds to all the tests I have mentioned, and the diagnosis is easily made. One of the first questions you will be called upon to answer when consulted by a patient with varicocele is: Will this produce atrophy of the testicle and loss of functional power? This you may answer in the affirmative with certain reservations. In almost every instance the testicle upon the affected side is smaller than natural, but that it has wasted away as the result of the disease is not always true. In most instances this testicle has not decreased in size but has been arrested in its development by the disturbance of circulation attendant upon the presence of the varicocele. Sometimes the testicle is congenitally small. Impairment of function is difficult to determine in the case of a single varicocele, for the unaffected testicle may supply all deficiencies, but in the case of a double varicocele the conditions are changed, and we find several cases of double varicocele on record in which no seminal secretion was present until the varicocele

had been treated by operation and the testicle had attained the normal size. In one of these cases the seminal discharge made its appearance soon after the cure of the left varicocele, and in another case in which the discharge had been scanty and thin the cure of the varicocele was followed in time by a thick, natural secretion. The possibility of injury to the testicle and procreative powers by the presence of the disease must be therefore admitted, but with the distinct understanding that the probability of such injury is not very great.

The treatment may be palliative or radical. The former is the one generally recommended and in the majority of cases is quite sufficient. The most simple and most satisfactory expedient is the wearing while in the erect posture of a well-adjusted suspensory apparatus, that known as the United States Suspensory serving all purposes. An equally good one can be made in a few minutes of clean muslin, and in some respects it is more favorable than all others because of the ease with which it can be kept clean. Instead of this the skin of the scrotum may be drawn through a soft silver ring, covered with wash-leather which is then made to squeeze the tissue. When, however, there is sharp neuralgic pain, whether continuous or intermittent, that does not yield to treatment; when there is tenderness which is persistent; when the varicocele is rapidly increasing in size; when its presence prevents one from following his chosen profession, such as an army or navy career; when there is intense dislike to wearing a suspensory bandage, as in the case before you; when there is marked impairment of the testicular function, or when, as in the case operated upon before you some weeks ago, the patient is in such constant fear of impotence that his mind is unsettled, then a radical operation is demanded.

A number of operations have been advised and practiced such as castration, excision of the scrotal wall, injection of perchloride of iron, excision of the veins and subcutaneous ligature of the veins. The last two are the only ones that need consideration. In very severe cases in which there is

great elongation of the cord, the testicle being three or four inches lower than normal, open excision of the veins and immediate shortening of the cord, as recommended by Bennett, is a satisfactory operation; but in a majority of cases, in my estimation, no operation compares in simplicity and freedom from danger to subcutaneous ligation. It is by this method that I propose to operate to day.

The patient has been prepared for the operation by shaving the scrotum, scrubbing it with a sublimate solution and then washing it with ether. He will take no anæsthetic because I desire to have him stand in order to distend the veins and thus facilitate the operation; instead, at the point where I propose to make the puncture I will inject a few drops of a four per cent. solution of cocaine. I now take two needles (straight) known as Keye's varicocele needles, and a piece of strong silk that has been thoroughly soaked in a sublimate solution. The first step in the operation is to separate the vas-deferens from the veins, at a point near the attachment of the scrotum to the perineum. This is easily done by rubbing the mass between the thumb and finger. The vas-deferens has a dense, wiry feel, and as I squeeze it tightly slips between the thumb and finger to the inner side of the scrotum. Now holding it in place, I take the threaded needle and pass it through the scrotum from before back and between the duct and the veins.

The needle is left in position while I take the second needle with no thread and introduce it into the same opening and by the side of the first needle. Having passed it through the dartos the point is carefully worked in between the dartos and the veins until it is made to emerge at the same opening with the first needle. This is the most difficult part of the operation, and should be carefully done so as not to puncture the veins. Having accomplished it satisfactorily I detach the thread from the first needle and introduce it into the eye of the second needle, and withdraw the needle. This completes the circuit of the veins.

The thread is now tied securely, considerable force being needed in order to occlude the veins. The ordinary sur-

geon's, or double-knot, is not used, because of the great difficulty of tying it tight enough without using such force as is liable to break the thread, a very disagreeable but not unfrequent occurrence. Instead, the loop is held firmly by my assistant, which prevents slipping, until the second loop is finished. The ends are now cut short, and as the walls of the scrotum are lifted up, you notice the knot becomes subcutaneous.

The first needle is now withdrawn. It has been left all this time, because its presence is no obstacle to the performance of the operation, and should the thread break the second needle need only to be inserted. A pad of sublimate gauze is applied, the scrotum swung in a suspensory, and the patient put in bed. In twenty-four hours he will be allowed to go about his room, and in four or five days he will be out. He will probably have little or no pain. Some induration at and below the ligature will be present for four or five weeks. As to the final results, I have no doubt but that we will have a complete cure. I am glad to be able to report that the patient operated upon before you in the early part of the winter's session writes that there has been no return of the trouble, and that not only has the distress which he experienced disappeared, but that the scrotum is much smaller in size.

Before I leave this subject I want to say a few words concerning the method of treatment by open excision of the veins. The occasional failures that follow subcutaneous ligature of the veins, and the possible danger of transfixing a vein in the process of encircling the varicocele has led some operators to advocate open excision. Both of these dangers may be entirely obviated by care, and there seems to me no good reason for taking the additional risk that is quite generally admitted to be a consequence of open excision, unless the operator desires to go a step further and produce an immediate shortening of the cord, as practiced by Bennett. This operation I have made but once, and sufficient time has not elapsed to enable me to say anything concerning its value from personal experience. In severe

cases I believe it will prove a valuable procedure. In varicocele there is not only enlarged veins, but elongation of the veins and cord, in some instances the testicle on the affected side hanging three or even four inches below its companion. The destruction of the veins does not in severe cases assure a shortening of the cord, and after the operation the testicle may still remain pendulous. To remove this difficulty, Bennett proposed immediate shortening of the cord, sufficient length of vein being restored to bring the testicle into its normal position. The operation is performed as follows :

The ordinary antiseptic precautions having been taken and the patient anæsthetized, the testicle is put upon the stretch and an incision an inch or two long is made over the prominent veins at a point about midway between the testicle and the ring. This incision is carried down to the fascia surrounding the veins, but the veins are not denuded. The vas-deferens is separated as in the sub-cutaneous operation and held out of harm's way. An aneurism needle, threaded with a strong carbolized tendon or cat-gut is passed around the veins outside of the fascia and drawn down to a point near the testicle where it is securely tied, the ends being left long. As much of the varicocele as is deemed necessary to excise in order to make the cord the natural length is now separated with its sheath from the surrounding parts and a second ligature passed around the veins and tied in a single knot. The portion between the ligatures is then excised, and the tying of the upper ligature completed. All bleeding having been arrested and the wound thoroughly douched with an antiseptic solution, the cut ends of the cord are brought together and held there by tying the ends of the upper ligature to those of the lower, thus lifting the testicle at once to its normal position. The ligatures are cut short and the wound dressed with an antiseptic dressing without suture or drainage tube. By this means the operator insures the ligation of all the veins, for he does not separate them from the sheath in which they are found ; he also insures a shortening of the cord



and elevation of the testicle. It does, I believe, add to the dangers of the operation, but under antiseptic precautions this danger is reduced to a minimum.

I do not advocate the operation in ordinary cases, but in severe ones in which the patient demands a more perfect result than can be obtained by the sub-cutaneous procedure, the claims of this operation should certainly be considered.

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### TUBO-OVARIAN DISEASE VERSUS PELVIC CELLULITIS.

EXTRACTS FROM A CLINICAL LECTURE IN THE POST-GRADUATE  
COURSE IN THE HAHNEMANN HOSPITAL, OF CHICAGO, BY  
PROF. LUDLAM, MARCH 16, 1889.

Of the three laparotomies which the different members of the post-graduate class have seen me make within the last ten days, one was for the removal of a parovarian cyst weighing twenty-one pounds, and the others for the extirpation of the ovaries and tubes in old intractable pelvic disorders. Here are the specimens obtained, and I am glad to say that the patients are recovering without any unpleasant symptoms.\*

The last two of these cases deserve more than a passing notice, and suggest the propriety of discussing the clinical history of diseases of the Fallopian tubes and of the ovaries in connection with that of pelvic cellulitis and abscess. The first one was brought hither by Mrs. Dr. M. A. Kester, of Topeka, Kansas, with the following history:

*Case.*—Miss Dr. —, æt. 31, began menstruating at 17 years of age. From the first she suffered with membranous dysmenorrhœa. In April, 1887, she was thrown violently across the dash of her buggy, striking the lower part of the abdomen on the sharp corner of the dash. The following June she was ill all the month with severe pain in the left ovarian region, and more or less fever and general malaise. She dreaded to go to bed at night for fear that she would not be able to leave it in the morning. July 3d

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\*April 10. They have all gotten well and returned home.



FIG. 1. THE OVARY, THE TUBE AND THE PUS-POUCH.



she was taken with an intense pain just over the pubic bone, while in her office; so severe was it that she was unable to stand long enough to telephone for help. Some friends found her an hour or two later and took her home with them. The pain became unbearable, and chloroform was resorted to. In a few days an abscess pointed and broke on the right labium externally, discharging a large quantity of offensive pus. Although the weather was very warm, she complained all the time of being very cold, and had to be wrapped in blankets with hot-water bags around her. A peculiarity of her suffering was that her flesh and even the bones felt as if bruised or crushed, and she would ask her friends to raise her hand, so that she could be sure that it was not really crushed. All the time there was copious hemorrhage. I saw her about the middle of July. She then talked of going home to her family in Detroit, Mich. Upon making an examination I found the soft parts swollen, hot, tender, and a decided bulge on the left side of the uterus, well up in the roof of the vagina. A week later she started for Detroit, being carried from her bed to the berth in the sleeper.

There she was again seized with terrible pain in the left ovarian region, accompanied with violent vomiting, which kept up at intervals of ten minutes for seventy-two hours. A peculiar symptom developed at this time; if she turned her head to the right it caused violent sneezing or vomiting, which aggravated the pain and the hemorrhage. She was treated homœopathically, and by September 1st was back in her office, but was still very sore and tender.

About November 25, 1887, she was again seized with intense pain which continued three days, when there was a profuse discharge of pus and blood per vaginam. This gave some relief and she started out to make her professional calls, but fainted at the first house and was taken to the home of a friend, where the experience of the preceding summer was repeated. Terrible pain, coming on every afternoon, lasting from one to four hours, with hemorrhage and discharge of pus. There was at this time an opening on the inside of each labium and one in the roof of the vagina. She was unable to resume practice until February, 1888. In December, 1888, she again commenced flowing profusely, and continued to more or less until the operation March 3, 1889. I was again called February 1st and found that the old trouble had returned. Her pain was intense, coming on every afternoon and continuing from two to

three hours. This had already been repeated for six days. I advised an operation and urged her to go to Chicago.

The additional facts are that she has never passed a monthly period without the most atrocious suffering for twelve hours or more, and that in all she has had four abscesses, three of which have discharged from the left and one from the right side.

The operation was made March 3rd, at which time both of the ovaries and both of the tubes were removed. The left ovary was not so large as the right one, but its tube had developed into a large pouch, which was bound to the ovary by very firm adhesions, while its fimbriated extremity had formed a pus-sac that would hold about two ounces. (Fig. 1.) The right ovary was six times the natural size and cirrhotic like its fellow, while the corresponding oviduct was very much thickened and enlarged in its outer two-thirds.

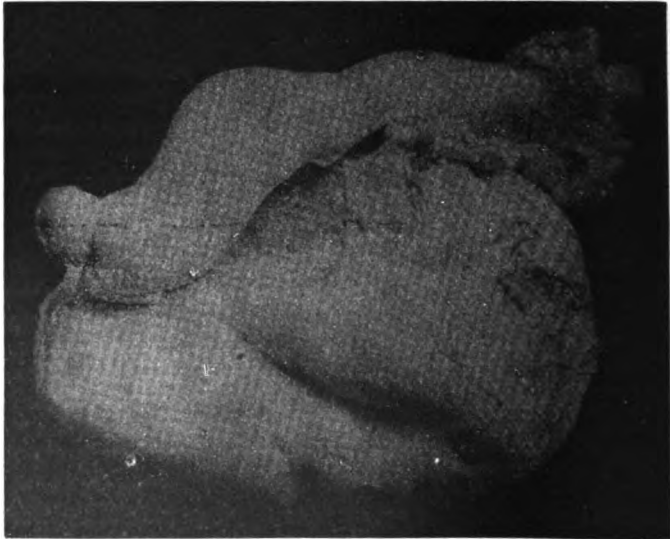


FIG. 2. THE RIGHT OVARY AND TUBE.

(Fig. 2.) The evidences of previous peritoneal inflammation were especially pronounced in the left side of the pelvis. There were no signs of pus in the peritoneal cavity.

The other patient was sent to the hospital from Tennessee and the following is the record from our case-book:

*Case 20,340.*—Mrs. M., æt. 28, was admitted to the hospital February 12, 1889. She was married at 17, since which time she has always been ill. She has been treated for various diseases, as gravel, uterine displacement, nervous prostration, dysmenorrhœa, rheumatism in the shoulders and arms, pain in the ovarian region, and for dyspepsia for weeks together. She has also been told that her lungs are weak, that she has "bronchial trouble" with much sore throat. She has never been pregnant. Local examination finds the uterus acutely anteflexed, and the vaginal cervix extremely tender and sensitive. The os-uteri is slightly torn in consequence of the forcible dilatation that was practiced for the relief of the dysmenorrhœa.

February 20th, during menstruation, she passed an almost complete cast of the uterus, which cast is very thin and diaphanous, the result of an exfoliative endometritis. This was accompanied with the usual severe monthly suffering and with extreme nervousness, bordering on hysterical spasms, to which she has been subject under these circumstances. The menstrual flow is free but not long continued, and is sometimes followed by a discharge of pus. The pain is chiefly in the ovarian and inguinal regions, and is evidently due to a relapsing peritonitis.

February 27th she was examined in the clinic and, although an accurate diagnosis could not be made out, it was decided that, in all probability, there was disease of one or both the Fallopian tubes and possibly of the ovaries also. An explorative laparotomy was accordingly advised.

In this case the operation was made in this amphitheatre yesterday morning, March 15th. You remember that it was begun as an explorative expedient, for a double purpose, (1) to reach an absolute diagnosis, and (2), in case it became necessary, to remove the ovaries, or the tubes, or both and all of them. The steps of the operation are fresh in your minds, and also the fact that while I found the left ovary and its tube to be healthy and normal, the right one was diseased, and had to be taken away. This proved to be the seat of the mischief, for it was a case of pyosalpinx in which the tube had become sacculated, each compartment

being a pus-pouch, and all of them having an exit through its inner extremity into the uterine cavity. (Fig. 3.)

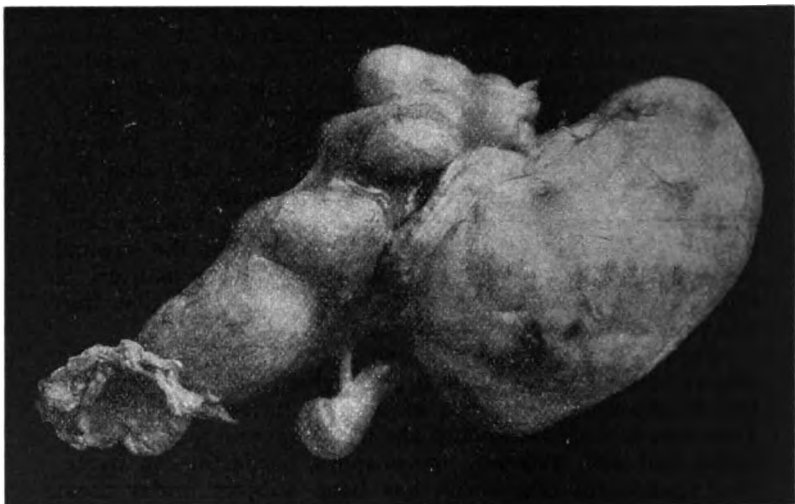


FIG. 8. SACCULATED TUBE AND OVARY.

In 1856 my old teacher, Bernutz, of the Hospital de la Charité, in Paris, made the first careful dissection of several cases of pelvic peritonitis, named the disease, and published an accurate diagnosis between it and the only form of pelvic cellulitis which he could identify, and which he thought fit to recognize, *viz.*, abscess of the broad ligament. In all of them he found there was present the most decided evidence of disease of the ovaries, and of the tubes, and with his keen clinical insight determined that intra-peritoneal abscesses were due to the conveyance of infectious material through or by the tubes to the ovary, inducing the feminine orchitis, or into the peritoneal cavity, where plastic inflammation was set up and circumscribed abscesses were formed.

For almost thirty years this remarkable discovery failed to be understood and appreciated. It is only since the resort to tubo-ovariotomy, and to the expedient of explorative laparotomy in chronic and forlorn cases of pelvic dis-

ease that it has been verified and put to a practical use. In no other direction have the results of peritoneal surgery been more surprising or more satisfactory. \* \* \*

It is generally conceded that peri-uterine cellulitis is rare in the case of women who have never conceived, and yet the occurrence of peritoneal abscess in this class of patients is by no means infrequent.

Child-bearing often gives exemption from dysmenorrhœa, while it greatly increases the risk of what is usually called pelvic cellulitis. Some of the worst cases of painful menstruation that we meet with are associated with the periodical discharge of pus through natural or unnatural outlets. If dysmenorrhœal suppuration is common among the unmarried and sterile, and peri-uterine abscess is not so, there can be no necessary connection between the formation of pus and the occurrence of inflammation of the pelvic areolar tissue. Manifestly, we may have one without the other, and our old notions of the clinical history of these lesions must be modified. \* \* \* \*

But how can pelvic peritonitis give rise to the symptoms of cellulitis and result in the formation of abscess, whether in puerperal or non-puerperal women? In the former by the extension of the puerperal mischief from the uterine cavity along the oviduct to the ovary, and to the peritoneum; in the latter by a similar transfer of gonorrhœal, catarrhal, or of other infectious material in the form of pus, or mucus, or of decomposed blood along the same channel, and to the same point. Arrived there, the septic or pyæmic accumulation is discharged into the peritoneum, where it excites such a degree of adhesive inflammation that it is soon imprisoned by false membranes, and kept from killing the patient through an attack of general peritonitis. When this pouch has been formed its contents must find a means of escape, or an outlet through the bottom or sides of the pocket into the rectum, the vagina, the bladder, or, as in one of the cases just cited, along the side of the vagina and through the labia majora.

The varying site of these secondary abscesses is easily



explained. The tube and its corresponding ovary may drift away from their natural position and become anchored in the Douglas pouch, in front of the uterus, low in the pelvis, or high in the abdomen. Wherever they may happen to be the morbid process that we have indicated may go on, and when an abscess has formed we usually refer it to cellular inflammation, when the whole mischief is intra-peritoneal, and, unless it perforates the peritoneum and points externally, has nothing to do with the areolar tissue. \* \* \*

It is this kind of peritonitis, with its propensity to form false membranes, that sometimes glues the intestines, or a portion of the omentum, with the Fallopian tube and the ovary into a mass that is easily mistaken for a tumor. Sometimes this mass is adherent to the abdominal wall in the iliac region, or over the bladder, in front of the rectum, and above the vaginal roof, where, especially if there is any discharge of pus, or evidence of suppuration, the supposition is that the case is one of peri-uterine cellulitis. In the last twenty-five years I have shown many such cases in this clinic, where I have convinced myself and a host of pupils that the lesion was undoubtedly due to pelvic cellulitis. We had no proof to the contrary. When we had gotten on far enough to tap some of them by aspiration a great point was gained, for the result was confirmatory and the recovery was hastened. Nobody had dared to cut down upon such a formation in the living subject, and our diagnosis was sometimes "a lame and impotent conclusion."

But now we know better. Thanks to the progress of gynecological surgery, and to its practical confirmation of the views of Beruntz, the way is literally open for a better diagnosis and for more skillful and satisfactory treatment in these and kindred cases. Where there is doubt and nothing else will bring relief, we can cut down upon a plaque or *plastron* of this sort, and if the bowels or the omentum are soldered together and to the abdominal parietes, in consequence of a benign peritonitis, we can separate them, turn them aside carefully and find the diseased tube or the ovary or both, or the abscess, if there is one, and excise

the one or drain the other, and so dispose of the whole difficulty. \* \* \*

A practical reason for differentiating between an abscess from exudation into the pelvic connective tissue and pyosalpinx, or ovarian abscess with peritonitis, whenever it is possible, is that their proper surgical treatment is very different. For while aspiration would be the right thing in the former case, it might be very harmful in the latter. It is only when the abscess is very low down and adherent to the vagina, that an opening by the needle or the knife should be indiscriminately made.

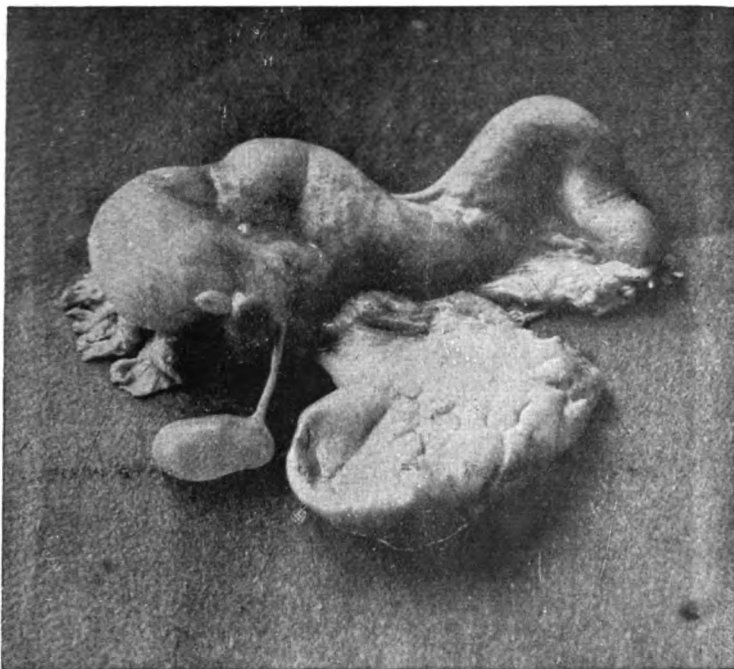


FIG. 4. HÆMATO-SALPINX.

But suppose that, instead of removing this tube (Fig. 1) with its enormous pus-pouch and its demoralized tunics, I had tapped it with the aspirator-trocar? Do you not see that, while we should have obtained a small quantity of

pus, the failure of the tissues to contract on the withdrawal of the needle would have involved the risk of purulent infection? Even if our patient had escaped such a mishap, is it not evident that the diagnosis would still have been imperfect, and she as badly off as before? And what of the other ovary, with its scar from the rupture of an old abscess and its distended tube? (Fig. 2.)

Or, if we take this sacculated tube (Fig. 3), what could we have learned or accomplished by aspirating either of its compartments through about two inches of adipose in the abdominal wall? \* \* \*

There is another phase of this subject that has great clinical significance. It is not unusual for physicians to direct their treatment to endometritis, to some form of uterine deviation, or to menorrhagia, as if they were always primitive affections; when they may depend upon peri-uterine inflammation and abscess. Our two cases illustrate this fact, and I could adduce many more of a similar kind. There is quite a share of cases of chronic endometritis, with or without any menstrual moulting, and disconnected with uterine sub-involution, that are secondary upon disease of the ovaries and tubes and a coincident peritonitis, and which can only be cured by getting at the root of the difficulty. We might have treated the case from which this sacculated tube with its multiple pus cavities was taken, until doomsday for her uterine flexion without curing the dysmenorrhœa and the chronic invalidism.

Here is a specimen (Fig. 4) that I removed from a patient of Dr. Coutant, of La Salle, for the relief of an intractable menorrhagia. It was a case of hæmato-salpinx of one of the tubes—the other being healthy—and you can readily understand why the doctor's well-chosen remedies failed to cure the hæmorrhage, and why the curette within the uterine cavity could not have accomplished any better result. But now that this diseased and offending member is disposed of, like a decayed tooth, the woman is all right again.

In the case of a woman aged 34, a patient of Dr. E. Z.

Cole, of Michigan City, and upon whom I operated three weeks ago for the relief of a relapsing peritonitis, violent dysmenorrhœa and sterility, recovery has followed promptly. One ovary was left and she has since menstruated for the first time in many months without the slightest pain or discomfort. Here is the offending ovary and tube, with an enlarged hydatid of Morgagni (Fig. 5). \* \* \*

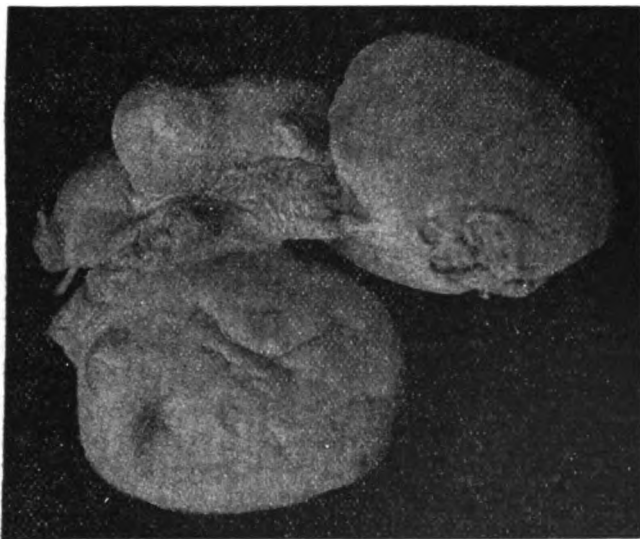


FIG. 5. OVARY, TUBE AND ENLARGED HYDATID OF MORGAGNI.

The fact that it is possible to shell out and to separate these diseased organs by gently tearing away the false membranes which surround them proves that their adventitious capsule is not formed of cellular tissue. If they were located in the connective tissue that intervenes between the layers of the broad ligament, where they would be outside of the peritoneum, it would be impossible to remove them without leaving a diseased structure or suppurating surface behind. \* \* \* \* \*

I have spoken of but one of the routes by which infectious matters may penetrate the intra-pelvic tissues. It is not the only one, but in non-puerperal cases it certainly is

the most natural and the most important one. And in some of the secondary affections of childbed also the oviduct is the channel through which the noxious material is drained from the uterine into the peritoneal cavity. This is notably so in puerperal peritonitis when it occurs after the first week of the lying-in, and hence the significance of a relapsing tubo-ovarian peritonitis that dates from labor, no matter how long an interval may have elapsed since the child was born.

Doubtless the uterine lymphatics afford a means of transit for septic materials from the cervical and the vaginal mucous membrane to the areolar tissue within the pelvis. This is the explanation of abscess within the broad ligament when it follows a traumatism of the soft parts, the use of unclean instruments, or dressings, and the lack of antiseptic precautions in labor, or in the performance and the after-treatment of the minor gynecological operations. But we must not forget that the peritoneum itself is an expansion of lymphatics, and that in case of infection from the placental site, or from a lacerated cervix, or vagina, or vulva, it would be less likely to escape than the cellular tissue, even if the latter were more abundant than it really is about the neck and the sides of the womb.

It may happen that an abscess of the broad ligament shall follow the rupture of an over-distended tube in pyosalpinx. Here the discharge, coming from a break in the lowest and weakest portion of the tube, would be turned directly into the cellular tissue lying within the broad ligament, and consequently we might have to treat a double abscess that would tax our surgical skill very severely.

\* \* \* \* \*

In calling your attention to this subject my desire was not to throw doubt upon the existence of pelvic cellulitis, but to show that, in the light of recent investigation and of increased experience in peritoneal surgery, we are forced to believe that many cases which were formerly thought to be of that kind should properly be referred to tubo-ovarian disease with an accompanying peritonitis.

## Clinical Society Transactions.

JOS. P. COBB, M. D., SECRETARY.

MARCH MEETING, 1889.

The regular monthly meeting of this Society occurred at the Grand Pacific Hotel at 8:30 P. M., of Saturday, March 30. Owing to a severe rain-storm the attendance was not so large as usual. The chief business of the meeting was to hear and discuss

### *THE REPORT OF THE BUREAU OF CLINICAL HYGIENE.*

J. E. GILMAN, M. D., CHAIRMAN.

THE HYGIENE AND DIETARY TREATMENT OF CONSUMPTION.—BY DR. J. E. GILMAN.—The majority of the general public have undoubtedly the impression that, when once consumption has fastened its hold upon an individual, it is but the question of a few weeks or months before the final ending of life; but to the experienced physician who recognizes the greatness of the conflict which must be undergone, and the imminent peril to which his patient is exposed, it is by no means so hopeless a task to overcome the disease. There are numerous cases of spontaneous recovery, and there are many recorded and unrecorded instances where phthisis pulmonalis had gained a foot-hold in the lungs, been ousted and a recovery ensued.

Dr. Flint reports from his note-books 640 cases during thirty-four years, with 44 recoveries (that is about 1 in 14); and he adds, that of these 44, in 23 cases no measures of treatment were used to which the recovery could be attributed—that is, the recoveries were spontaneous.

Loomis says recovery has occurred in one-sixth of his recorded cases during the past ten years. These represent the cases that came under the physician's hands after the

advent of the disease in force, and the deaths are in a great majority. But the incipient disease is more frequently checked and prevented from developing into activity by the hygiene and sanitary regulations that common sense and a knowledge of the character of the disorder would indicate, and we even should go farther back and treat presumed tendencies toward the disease; that is, the family history being such a record of scrofula, tuberculosis, syphilis, or other diseases that in the ordinary sequence of events we should expect tuberculosis to develop in due course of time. The child should receive a special course of training, and careful attention as to diet, exercise, and freedom from anything that would lower his vitality. If the infant has a mother of a scrofulous diathesis, or developed tuberculosis, the child should not be allowed to draw its nourishment from the mother's breast. A wet-nurse should be provided at once (before the babe loses its instinct for nursing), to furnish the best and most easily assimilated food for the nutrition of the growing organism. The attempt to rear such an infant on artificial food will almost inevitably fail, and during the period of dentition the tuberculous disease will probably be developed.

Tuberculosis is produced primarily by a process of malnutrition, and consequent lack of energy of the organs of circulation and excretion. Build up the nutrition of the individual to the fullest extent. I do not mean that the consumptive patient must be constantly stuffed with food. That is not nutrition, in its complete sense. Supply not only all the elements that enter into the composition of the human organism, but also the working power which is found in pure air and proper exercise. The germs settle on stagnating soil; in other words, an unused or only partially used lung affords that quiet protection required by the bacillus *tuberculosis* for its safety, and in supplying pure air there are fewer germs of disease to reach the respiratory tract.

As an instance of preventive treatment, let me call your attention to a case from practice: A lad, fifteen years

of age, came under my charge, I being the family physician. The family history was not favorable—several members of the family on the mothers' side having succumbed to pulmonary consumption, and the father having suffered from scrofulous and other disorders of a nature to lower the embryonic vitality. The child survived its infantile trials and illnesses without receiving any material injury from them. At the period of my acquaintance with him, I found a boy of very studious habits, a book or paper representing the highest pleasure that could be afforded him; his complexion was blonde, hair very light, the abdomen somewhat protuberant as compared with his size—not very much the matter with him except a derangement of the stomach of frequent occurrence, and headaches of some intensity in connection with the stomachic disturbance. The evidences of imperfect nutrition were found in the defective and easily decaying teeth, and the stubbed and irregular finger nails. This latter is characteristic of a consumptive tendency.

The beginning of the disease is in the failure of the ability to properly digest the food, and in these attacks, gradually increasing in frequency, might be discerned the advance of approaching pulmonary trouble. The family history, the physical appearance, and the digestive disturbance, all indicating what was to be guarded against. In this case, without waiting for the advent of a pronounced phthisis, I advised the family to take the boy out of school, to let him select some employment that should keep him out of doors and in as pure an atmosphere as could be selected; restrain his inclination to spend so much of his time in reading, and encourage his out-door exercise as much as might be possible. If this was not done, I argued that the soil was being rapidly prepared for the development of phthisis, which might be expected to have a permanent hold upon him between the age of 18 and 25, if he should succeed in controlling it even so long as that. The advice was acted upon and the boy was sent west. Becoming in some measure a cow-boy, his out-door life speedily gave him a vigor and impetus that wakened up the vital



forces, and in three years a marked change had taken place. Two years later he came east to New York State to attend school for a year. He staid through the larger portion of the collegiate term, but exhibited premonitory indications of consumption again. An easily excited cough, a tendency to colds to drift immediately to the pulmonary organs, a fatigue unwarranted by the exercise taken, and a general letting down of strength and soundness. A return to his Colorado home and the resumption of his out-door life has removed all the unpleasant symptoms, and restored him to as good health as the majority of men of his age. This case is a type of treatment that should be given when the circumstances are such that the patient can remove to a more suitable latitude. If this had been an impossibility I should have urged upon his parents the necessity of an out-door life, absence from any confinement within the school-room, care of his sleeping-room so that the air should be constantly renewed; care of the person, using all measures that would tend to harden the skin, such as bathing, rubbing, etc.; the use of such gymnastic exercises as would tend to develop the thoracic muscles especially and increase the breathing capacity. I should take all the possible precautions to increase the strength of the stomach and avert any indigestion—thus in the kind of food, and the manner and time of eating. In short, use very similar methods of exercise and general hygienic treatment to that adopted by the athlete, preparing for a contest in the arena. When the stomach begins to fail then the trouble begins; before that there is no immediate danger.

It is essential that the tuberculous patient shall receive a very liberal supply of nutrition, all, in fact, that he can take. This does not mean that he is to stuff himself full on every possible occasion, but it means the stomach must do all the work you can get out of it, and retain its strength and digestive power. This may be better accomplished by feeding the three meals of the day and taking a light, easily digested lunch between them. For instance, a cup of hot broth or cocoa if it agrees, the first thing in the morning

upon awakening, will aid the patient to dress without so much exhaustion as to destroy his appetite for the breakfast. Then midway between the breakfast and dinner a glass of milk and bread and butter, egg beaten up in milk with a little alcoholic stimulant if it is desirable. Koumiss, or some similar food, may be used between dinner and supper, also the last thing at night. While the three regular meals should consist of such kinds of food as are rich in nutritious substance, and not too compound in material to make it difficult of digestion. The likes and dislikes of the patient must be respected in the food question, but not so much the caprices. I mean by this that when there exists a long-seated dislike for some article of food it is not well to insist upon the individual using it. If it is something you think very desirable for him to use you may endeavor to rectify this idiosyncrasy by a gradual use of the article—tasting a little once in a while that is prepared in the very best possible manner, and sometimes the prejudice may be overcome. If, on the other hand, the patient desires food of which you do not approve, discourage the craving without actually forbidding the article; but if the demand still continues, gratify a little and test the effects.

Often nature thus points out the way to secure the substances needed in the organism. When this strong desire is present it is generally the case that nature will put forth such an energetic effort that it will digest things that judgment would condemn as inadvisable for use. Most patients enjoy and easily digest milk. When this can be obtained fresh from a perfectly healthy cow or goat it is well to use it freely, especially when freshly drawn, while the animal heat is still retained. For the remainder of the day it may be taken in its cooler condition, or with a little warm water, sugar of milk and cream added to keep up its standard of richness, or with a little lime water, if there is an inclination to turn acid in the stomach, or with the addition of whiskey when the stimulant is required, or in the shape of Koumiss or fermented milk when not contra-indicated.

Milk is a valuable article of diet and it is to be used in considerable quantities. Where the milk induces constipation this may be rectified by the admixture of barley water, or some mineral water may be used, or the addition of cream will sometimes relieve, or a larger portion of the sugar of milk. This latter substance is a valuable article for this difficulty. Sometimes the peptonized milk may be used to advantage, or milk from which the casein has been removed and known as whey, with or without the addition of cream. As to the use of alcohol, this is to be taken as a general rule when there is any exhaustion, or when considerable quantity can be used without causing any toxic effect or producing a headache. If the use of alcoholic stimulation causes throbbing in the blood-vessels and easily induced dizziness, with a feeling of depression after the first flush has passed, it is to be avoided or used with great care for some special emergency. Generally speaking, alcohol should be given in small and repeated doses of greater or less frequency according to circumstances. Alcohol also will sometimes aid in alleviating the discomforts of the cough; in this case it is a convenient method for use to saturate a lump of sugar with all that it will absorb, and this dissolved in the mouth will produce a soothing influence. Lemon-juice and sugar, or sugar of milk with alcohol will, in some instances, be serviceable for the purpose. It has been found that fat food is of great value in this class of cases, and the routine treatment of consumption has been the immediate prescription of Cod-liver oil. Valuable as this is, on account of its easy absorption and lack of tendency to disturb digestion, there are some patients who can not or will not take it, and it may be supplemented with quite as good effect with butter, olive-oil, bacon and suet. Glycerine has been used in those cases when the oil causes indigestion and has been of service; in fact, glycerine may be used for many purposes during the progress of a Phthisis, such as a food, as a lubricant to the dry parched lips; as a substance to relieve cough, and by virtue of its property of causing the exudation of serum or the watery portion of the

blood, it moistens the throat and relieves the thirst of a dry and fevered buccal surface.

The cream furnishes the oily substances in profusion, and buttermilk will agree in many cases and form a change from too much sameness. You can not lay down a cast-iron rule of diet to suit all patients. Even these statements, general as they are, must often be so modified that they are almost useless in some few cases.

That oil is used often when it is decidedly harmful there can be no doubt. Some patients use it with so much disgust that it is either ejected or so interferes with the appetite as to actually lessen the absorption of nutritive material. When the tongue is coated and there is a disordered digestion inducing a regurgitation of the oil it certainly is better omitted. Jaccoud recommends the use of very large doses when they can be taken, say gradually increasing the dose from one tablespoonful to four, twice daily, or in some cases even more, pushing it to the extent that it can be borne. I think while in some instances this may do, in the majority of the cases you will meet with, the use of other articles to vary the flavor of the hydrocarbons will be much more grateful to the patient and more serviceable to the case.

Jousset recommends in the beginning of Pulmonary Phthisis the use of what he calls a vegetable diet, consisting largely of farinaceous food, with milk as a basis. He says the aliment which appears to us the most appropriate in phthisis consists of farinaceous articles and milk; soups of all kinds, broths, purees, all vegetables including solids, all fruits and eggs; certain fish and shell fish also are allowed. This diet, however, he limits to the early period of the disease, and still further limits it by saying that it is to be used only by those patients who can easily digest the materials of which it is composed. A bad digestion, acidity, and above all a diarrhœa, constitute reasons for modifying or ceasing its use. This dietary is of service, in my estimation, among that class of patients who have earned a dyspeptic habit by surfeiting themselves with excessive eating of rich and indigestible food. This simpler diet, the

rest which the stomach obtains, and the clearing up of the system by better action of the systemic sewerage, would account for the feeling of relief which follows the alternative in the diet. In the whole matter of the diet of the consumptive individual, the stage of the disease, the nature of the case, the special needs of the individual, and his ability to manage nutritive substances must govern all the dietary regulations.

After the time has passed for Jousset's method to be of service, or in those cases where it is not advisable to use it, food may be demanded of an entirely different type, or it may be necessary to use the forced alimentation after the manner of Debove, who introduces the food into the stomach through a tube. This is done in those cases of anorexia where the patient is rapidly declining from the lack of proper nutrition, owing to the disgust for food. This condition would speedily end the case, and in some instances the food introduced into the stomach through a small rubber tube will furnish a nutrition that may develop an appetite. This tube is a serviceable method of syringing out the stomach, if inflamed—pouring into the stomach quite warm water through the tube used as a syphon. By lowering the end of the rubber, the water is withdrawn from the stomach without the disturbance of vomiting, thus giving it a warm or hot-water bath, and preparing the way for a reception of food without the dilution or discomfort attending the absorption of too much fluid.

As general rules for feeding, I should say that the patient should take as much aliment as he can possibly assimilate without exhausting or overloading his digestive organs. His appetite should be stimulated by air-exercise, and the choice of such viands as will be most acceptable and serviceable to him, omitting as much as possible those of inferior value as nourishment, or such as by their nature would interfere with the demands of a healthy stomach. Consult the positive desire of the patient for certain articles or types of food unless satisfied that it is a depraved and vitiated taste, or that it is of a nature to be absolutely harmful. Furnish

as much as possible those kinds of food which will not readily clog up the system with material which must be excreted, and give the food in cases of weakened digestion in smaller quantities, more frequently repeated.

These, however, are general rules, and require much modification for individual cases. There is in the scrofulous condition an imperfect or partially inactive excretion, owing to the slower glandular circulation. As a result from this follows the lessened activity in the repair of tissue, and the greater readiness to the deposit of pus in injured parts, and a tendency to local inflammation. With the disease comes also the weakness, as an accompaniment which lessens muscular exertion, and so favors the increase of the disease by lessening the excretion of effete material, and the distribution of a fresh supply. The breathing becomes less deep and full than it might be from the actual lung obstruction. The disinclination to take any exertion, causing the patient to use less and less of the respiratory movements, and as nature abhors a lazy or an unused tissue, causing it to shrivel away or become atrophied so that the lung-substance, as well as the thoracic muscles, suffer. From the lack of exercise the whole system loses vitality; so, some method of keeping up the circulation must be adopted.

Ling, when teaching the Swedish-movement cure, taught the great difference that existed between movements directed intelligently toward securing certain results and those that were taken simply as exercise. If the physician tells the consumptive patient to take exercise, and fails to direct what kind, how much, and when it is to be taken, he has failed of his duty in the premises. Says Weir Mitchell, "Ten movements of a sort adapted to his special needs are worth a hundred not so adapted. He has a narrow chest and drooping shoulders. This distortion results in displacement of the lungs, and yet he may have legs and hips comparatively vigorous. Ten movements concentrated upon these muscles, whose deficiency permits the drooping

of the shoulders, will be more valuable than a hundred for the legs."

Again, too much exercise is as bad, or worse, than too little, and consumptive patients require to be told how much they can take, and this definitely. The sense of fatigue is not always to be relied upon; for the pleasurable excitement of circumstances may cause forgetfulness of the actual weariness until the reaction comes. The effect which the exercise exerts upon the heart and the muscular system—generally the skin—the influence it has upon sleep, digestion, etc., must be the guide for lessening or increasing the character and amount taken. In some cases, when the weakness forbids any active exercise, or when from lack of habits of action we must begin with the simplest movements, massage may be used. This, however, is not allowable to any extent in that condition of weakness resulting from the profuse supuration, or destruction of lung tissue. Exercise in all cases must be taken, as much as possible in the open air. Riding or driving are to be used in many cases, and when the strength and lung-power will permit, climbing hills, etc., will increase the action of the circulation, and aid in the enlargement of the breathing capacity by expanding the lungs and increasing the action of the thoracic muscles.

Most of the special exercises in consumption are intended for the development of the chest, and some very remarkable cures have been made by well-directed movements of this character. It is a singular fact, that a great many persons do not know how to breathe, and only do the act in a very slovenly and imperfect manner. In consumption the lungs are often so obstructed, and the weakness or inflammation so interferes with the circulation of air throughout many of the air-cells, that there is generally a very superficial respiration, and portions of the lungs are not inflated at all, or only partially so. To increase the depth of the inhalation, and so lessen the frequency of the action, is very desirable. To this, and the taking as long inspiration as possible of pure, fresh air, is to be done frequently during

the day, and as a simple method of exercising the muscles of the thorax, if a little obstruction is placed upon both inspiration and expiration, by forcing the air in its passage to and from the lungs through a tube narrower than the main air-passage, so that it requires an effort to fill or empty out the air-vessels as rapidly as they demand. In the same connection the use of a spirometer, the instrument used to measure the quantity of air taken into the lungs, is to be recommended. In fact, before indulging in any other sort of exercise, the use of the tube, or the spirometer, or at least as full inspirations as can be made, should be required. The method of breathing adopted by some of the great vocalists—a method which gives them a greater lung-power by strengthening the respiratory muscles—is to be taught. This consists of making the movements of respiration full and free while holding the abdominal muscles rigid and as expanded as the inhalation has left them. In these efforts to fill the lungs with air, we not only supply the air cells with oxygen, but we, by the exercise itself—the actual motion interferes with the development of the bacillus of tubercle.

Koch has shown that it requires quiet and undisturbed possession to germinate well. So the exercise, the movement, interferes seriously with its spread, and in supplying the lungs with the larger amount of oxygen the blood revivifies the person to a much greater extent than when the respiratory act is incomplete. The additional oxygen increases the appetite and ability to manage the food, so that it is in the nature of a circle—one force operating to increase power, which, reacting, increases the original force again in return.

In consumption there is always a more or less congested condition of the lungs; most generally the pleura also is more or less involved, and it is necessary to relieve the engorgement as much as possible. We know the relief afforded to acute congestions, by dry cupping and such irritant applications as mustard and croton oil. These operate by diverting the blood from internal to external channels,



and thus relieving the pressure. In many cases this can be accomplished by some forms of exercise. Exercise may be either active or passive; that is, the patient makes the movement himself, or submits to be manipulated by some one else, and of the passive forms that of percussion is necessary when the patient is unable to take the exercise well alone, and especially whether administered by the individual, or some one else, in relieving the plethora of blood in the capillaries of the lungs. For indigestion and the atonic weakness of the stomach it is invaluable.

Not many years ago it was employed as a secret remedy for the cure of dyspepsia, with excellent results. The patient being sworn to secrecy as to the *modus operandi*, very severe attacks of indigestion may often be broken up in this manner, and a vastly improved ability to digest the food result from the following method of procedure: Over the pit of the stomach, the region of the liver and the upper portion of the abdomen. The percussion is applied with the hands, or by means of an instrument called a muscle-beater. This instrument may be improvised out of a piece of rubber tubing of one-half to three-quarters of an inch in diameter and a foot or so in length.

If the hands are employed, the blows are struck rapidly, but not so hard as to give pain. The muscles of the wrist and hand must be relaxed so that the hand is freely moved as though hinged. The palmer surface is used with the hand open so that the hand will fit all the inequalities of the body, and reach all parts alike. The slapping is done with the hands used alternately in rapid motion. If the rubber tubing is employed the process is the same, simply striking with the rubber instead of the hand. For the relief of the chest the strokes may be made on the back, on the sides or in front, avoiding in the latter any blows on the mammæ. The exercise may be continued as long as agreeable to the patient, and the strokes should be so distributed that they are not continued too long in one place.

Besides percussion, the use of such exercise as rowing or its equivalent in the gymnasium, the dumb-bells and

Indian clubs are to be advised. The development of the pectoral muscles, the increase of respiratory power and a better capillary circulation are gained by the well-directed series of movements into which these methods enter. In all of these movements and exercises the freest use of fresh air is to be inculcated, and the frequent inflation of the lungs before, during and after the exercise. The Italians have a proverb, "Where the sun does not enter the doctor must." So among the important elements in the treatment of consumption sunlight must not be forgotten. The example exhibited in the pale and sickly growth of plant-life developing in our cellars and in localities deprived of sunlight, teaches a lesson in hygiene of practical import. The sun's rays should be permitted to reach the invalid and kiss the pale cheeks into a semblance of health at least, and the direct influence of the rays of the sun in purifying the atmosphere of an apartment is well understood. If the sun's caresses are too ardent a long exposure of the invalid to them is not desirable; but each day the consumptive should endeavor to secure such exposure to the sun's influence as the weather may allow and the disease will permit. He should never occupy a room in which the sun's rays do not enter at some period of the day. The influence of these shut-up apartments which by means of faulty construction or unfortunate location are so placed that the sun fails to enter, is well understood as a prime factor in inducing scrofulosis and consumption. No more certain impulse to the downward course can be given a patient than to condemn him to the use of such rooms for sleeping or living purposes.

**VOLUNTEER PAPERS.—THE URINE IN BRIGHT'S DISEASE.—**  
**By H. N. LYON, M.D.—**At the onset of the attack the amount of urine will be greatly decreased, or even totally suppressed. Then as the stage of exudation begins the amount will be increased to above the normal.

The exudation, which at first consists of leucocytes, soon becomes almost pure albumen, owing to the cells of the glomeruli becoming so altered as to permit the escape of that material from the blood. When this condition has existed for a short time a sympathetic disturbance of the

other organs occurs, resulting in an imperfect reduction of the waste matters of the system. This is shown by the presence in the urine of uric acid and the urates. Owing to the presence of the urates, which are held in suspension by the albumen, the urine has a turbid appearance.

About this time a change occurs in the character of the exudate, which becomes of a thicker consistence. This not passing readily along the tubes becomes hard, giving us a mould or cast of the tubes. During solidification these casts shrink, and so become loosened from the walls of the tubes, from which they are finally washed out.

These casts, which are called the hyaline, consist of a homogeneous, transparent material, having a refractive index but little greater than that of water. Accordingly, they are almost invisible when immersed in that fluid, and it is only by great care and a skillful use of the microscope that their presence can be detected. It is impossible to convey a correct idea of their appearance by means of a drawing, but they may be represented by suspending a few shreds of colorless transparent gelatine in a dish of water.

If the trouble is not arrested at this point a destructive action occurs and the tissues begin to break down. This commences in the epithelial lining of the tubes, the cells of which become detached and are washed out by the urine. These cells are soon replaced by others, only to be in turn lost. Owing to the lessened vitality of the part these cells are less perfect each time, and if this condition continues long the departure from the normal type is quite pronounced.

The casts which are now formed present a covering of these epithelial cells, giving us what are known as epithelial casts. These in turn give way to granular casts formed by the débris from broken down cells and granules of the urates becoming mixed with the exudate before it has become hard. The terms hard and solid are here used only in a relative degree in contra-distinction to the fluid state, as the casts have but slightly greater consistence than firm jelly.

During the entire course of the attack the urine is acid in reaction. The specific gravity varies, for while the total amount of solids remains about the same, the amount of water is different at different times. While the amount of urine excreted is subnormal, the specific gravity may rise to 1.030, or even above, and later when the amount passed is above the normal it may fall to 1.010, or occasionally to

1.006. The amount of urine excreted is always diminished and is apt to cause acute uræmic poisoning. Albumen is present throughout the entire course of the disease.

The disease now being at its height, we will find on making a microscopical examination of the sediment, hyaline, epithelial and granular tube casts, epithelial cells, singly and in masses, red and white blood corpuscles, more or less altered from their immersion in the urine, granular matter from the destruction of epithelial cells, crystals of uric acid and amorphous granules of the urates. Of the urates the urate of sodium is the one predominating and may occur in the crystalline form, as in the illustration.

This is the characteristic urine of acute Bright's disease or acute parenchymatous nephritis. While this may develop into the chronic form—chronic parenchymatous nephritis—such an occurrence is rare. The chronic form usually steals on insidiously and its presence is not known until the patient suddenly gives out and a bloating of the face or extremities is observed on first arising.

In this form we will have the same general characteristics of the urine as in the acute condition. The red blood corpuscles are not often found in numbers except during an acute exacerbation, while in the acute form they may be present in sufficient numbers to give the urine a distinctly brown color.

As the case progresses the amount of sediment will increase and the tube casts become larger in size. Occasionally casts are found that have a central portion of a different composition or color from the cortex. This is caused by a cast formed in one of the small tubes becoming arrested in its passage outward and receiving a coating of the material poured out at that point.

In extreme cases the character of the exudate becomes so altered that instead of a transparent material we have an opaque glistening substance resembling wax. These waxy casts are usually of large size and have a light yellow color. In this form the amount of albumen present in the urine remains constant from day to day, but the amount of urea varies, being greatest when there is a large amount of urine. The amount of albumen is greater than in the acute form.

From the breaking down of the cells we get a fatty degeneration of the tissues. This will appear in the urine as globules of fat, cells containing fat globules and casts also containing these fat globules. This condition is occasion-

ally observed in the acute form, and wherever found, if persistent, is a serious sign.

The following is a drawing of the deposit in a case of chronic Bright's disease at an early stage. Hyaline casts were present in large numbers but, as before stated, it is impossible to represent them in a drawing.

The objective used was a quarter-inch. The actual magnification, as measured by the stage micrometer, .225 diameter.



*A.* Fibre of vegetable origin resembling a waxy cast. *BB.* Crystals of urate of sodium. *CC.* Epithelial casts. *D.* Epithelial cells. *E.* Cell showing fat globules. *F.* Red blood corpuscles, both normal and distorted from the action of the urine. *G.* Granular casts. *H.* Leucocytes. *I.* Uric acid crystals.

The finding of albumen or tube casts in the urine is not necessarily an indication of a serious trouble unless this condition is continuous. The progress of the disease can be more exactly determined by frequent examination of the urine than by any other means, as it often occurs that the general symptoms of the patient appear to improve while the disease is actually drawing to a fatal close. When the amount of albumen and of the organic elements in the sediment begin to decrease and the urine otherwise approaches its normal standard a favorable termination may be expected. If, however, the quantity of albumen increases and the amount of organic sediment becomes greater from day to day, the result will be the opposite.

**CEREBRAL ABSCESS.**—REPORTED BY BELLE L. REYNOLDS, M. D.—*Case.*—Freddy A., aged 7 years, was brought to the Home for the Friendless by an officer of the Humane Soci-

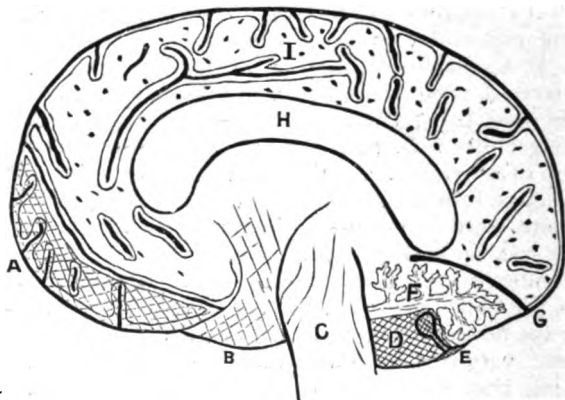
ety, the latter part of September, 1888. His mother was a dissipated woman, and when the boy came to the Home she was taken to the Bridewell to serve out a sentence for drunkenness and vagrancy, and has not since been heard from. He presented a forlorn appearance, being dirty, ragged, and half-starved. He had no sleeping-place but the parks, and no food but that obtained by begging from door to door. Mentally the boy was dull and slow of comprehension, never violent or irritable. His new surroundings were kindly accepted, and there seems to have been nothing especial to require the services of the physician, Dr. J. P. Cobb being then in attendance, until Saturday, February 16, 1889, when the care-taker came to me and said that he had had a chill the day before, "not to shake, but creeping chills with blue fingers and face," and now complained of a headache. No other symptoms being brought out I gave him Gelsemium 3, and waited results. Sunday there were no new symptoms; his headache was better and he was up and about as usual.

Monday morning, however, I found him delirious, lying across the bed—he would not lie in any other way—reaching to the floor, picking at imaginary things, also at the bedclothes; very restless, but totally unconscious of any one or anything that was said or done about him. The tongue was dry and brown, the skin hot and dry, except a profuse perspiration about the head and which stood in drops all over his face. Temperature 101°, pulse 98.

Tuesday, 19th. The patient lies quietly; limbs extended, the hands folded across his chest except when picking at his lips or other parts of the body. The head is turned to the right and he objects to having it moved at all. The right eye is closed, and the lids are glued together with a purulent discharge. On opening the lids the eye-ball is motionless with a dilated pupil, and does not respond to light or motion. The left eye is open but he sees nothing, apparently, and there is a convulsive drawing of the left eye-ball toward the inner canthus. This is accompanied by a panting respiration lasting a few seconds, and ending with a sigh as of exhaustion, to be repeated in a few moments. The urine is scanty, the tongue dryer and browner, with an almost black line down the center. He sometimes slips down entirely out of sight under the bedclothes. The sweating of the head and face are lessened, deglutition is impeded by an apparent paralysis of the right side of the tongue or some swelling of the glands on that side, but he

has taken milk and water every two hours. Temperature  $102^{\circ}$ , pulse 120. There is marked abdominal tympanitis to-day, for the first time.

Wednesday, 20th. Deglutition is impossible. The convulsive twitchings of the left eye-ball are more frequent but not more severe; he is still unconscious; the urine is suppressed. The temperature has dropped to  $98^{\circ}$  and the pulse is wiry, thready and can not be counted. He died quietly at 12 a. m.



*A.* Inf. frontal lobe—degenerated. *B.* Tissue disorganized and infiltrated with pus. *C.* Pons varolii. *D.* Degenerated portion of the cerebellum. *E.* Pus cavity and sinus in the same. *F.* Cerebellum, normal. *G.* Enlarged blood vessel. *H.* Corpus callosum. The areas of degeneration are represented by shading:

An autopsy was made by Drs. J. P. Cobb and H. N. Lyon, of which they kindly gave the following report:

The brain was removed on the morning of February 22d, and frozen; on the 24th it was carefully examined. The meninges of the base were highly congested; tubercles were not discovered on the meninges, but we regret to say that a microscopical examination of the meninges was omitted. A median vertical section was first made and the two halves examined separately; the left by transverse, the right by vertical sections, with the following result:

*First.* The whole brain was hyperæmic, the white matter being distinctly rosy.

*Second.* The lateral ventricles very much distended with ice, which melted into a clear serous fluid—that removed from the left ventricle measured three drachms; that from the right, one and one-half drachms (some was

undoubtedly lost). The fourth ventricle contained a purulent fluid.

*Third.* The anterior inferior quadrant of the cerebellum was softened and all trace of the white matter had disappeared. This was more pronounced on the left side. Slightly below the center in the median line of the cerebellum, was a sinus leading to a cavity within the cerebellum, connecting it with an excavation existing under the meninges. The cavity was about the size of a large pea, and together with the sinus was filled with a puriform fluid which the microscope showed to consist of broken down brain tissue and pus. The excavation on the surface was filled with pus. The tissue around this cavity and sinus was disorganized.

*Fourth.* In both inferior frontal lobes an extensive degeneration had commenced, involving a greater part of the lobe. The tissue was much softened but had not yet broken down; degeneration was more pronounced in the left lobe.

At the fissure of Rolando, just under the meninges, was a sanguino-serous effusion. On the base of the brain anterior to the pons varolii the tissue was partially disorganized, and on the left side there was a collection of pus which undoubtedly exerted more or less pressure upon the third, fourth and fifth nerves.

THE CAUSATIVE RELATION BETWEEN DISEASES OF WOMEN AND NEUROSES.—TRANSLATED FROM HEGAR, BY W. F. ROBINSON, M. D.—*Concluded from page 66.*—Another source of nervous phenomena is the contractive processes connected with the severe forms of vaginal catarrh as seen after the climacteric, and sometimes in younger women. In cases of severe vaginal contraction which may sometimes even amount to stricture, coitus is especially harmful. In other cases the contraction, and especially the emptying of the blood-vessels, is not equal in all parts. Thus arises local congestions in the collateral circulation, and isolated reddish spots appear with prominent and deeply injected papillæ, a condition of the parts which may give rise to severe irritation.

Moreover, both simple and infectious catarrh of the vagina, with swelling of the papillæ, are often the cause of the most annoying neurotic phenomena. If these troubles persist, they do not by any means remain at the point where they started, or in the immediate neighborhood.



Their further spread is generally favored if, because of itching and scratching, the sexual feelings are stimulated.

Gaping of the vaginal entrance may exert an unfavorable influence, as the upper portions of the vagina are thus exposed to the admission of harmful agents from without. If the nerves of any locality are affected in any of the above-mentioned methods, there usually follows a transition to the remaining nerves of the sexual system, and to the remaining parts and organs. The trouble does not remain confined to this system, however, but soon extends to more distant parts. It also happens that a certain nervous region may become affected and remain so for years at a time. However, the whole nervous system is generally affected, either in the form of extreme irritability or in that of neurasthenia. Certain consequences of the neurosis, as sleeplessness, loss of appetite; or the complicated action of the sexual trouble, as loss of blood, or fluor albus, may contribute very materially to the production of this result.

From all that has been said we may conclude that we are not in a position to demonstrate or absolutely to prove the casual relation between sexual diseases and the neuroses. We are, therefore, as in medicine and in common life reduced to indications, and must form our opinions from a consideration of each separate sign, the significance of all taken together, and of the whole course of the disease. We are also compelled in each separate case to seek for other possible causes of the neurosis, and to apply the method of diagnosis by exclusion. This matter is often extremely complicated, and one can not always disprove the participation of every other etiological factor, but can only determine what part each factor plays in the origin of the trouble. Besides, a secondary condition will sometimes play such an important role as to transcend in importance the original cause.

Under this head must be mentioned local troubles and anomalies of other parts and organs. The genital apparatus is not alone possessed of the power to cause nervous disturbances. Pathological processes occurring elsewhere may, either through reflex channels—through injury to the nutrition and blood-formation, or through participation of the "psychical" or emotional-intellectual sphere—produce neurosis and general neuropathy. We must be careful, in order to avoid falling into error regarding the origin of any trouble, to keep in mind the abdominal cavity and its walls. We know that diseases of the stomach and intestines often

give rise to nervousness, hypochondriasis, and even to mental troubles.

We have already mentioned that abnormal relaxation, or paralysis of the abdominal walls and abnormal mobility of the organs contained in the cavity, may produce tension on the mesentery and spinal symptoms. So also an unnatural position of the spinal column, caused by weakness of the abdominal muscles and continued over-action of the dorsal extensors, may act in the same way. It must not be forgotten that a disease located in any organ may give rise to a neurosis, by first causing an affection of the sexual apparatus. An example in which I was myself deceived may serve to explain my meaning :

The patient was unmarried, and suffered with irregularity of the menses and menorrhagia, and in addition to other nervous systems general convulsive attacks, coming on with the menses and accompanied with loss of consciousness. There was present mitral insufficiency, enlargement of the uterus, and adhesion and swelling of the right ovary, which was also affected by follicular cystic degeneration. Castration was performed on account of the uterine hemorrhage, as well as for the neurosis, and the veins of both ligaments were found to be dilated. The result was, strange to say, very satisfactory, although not perfect. The attacks return now only once or twice a year. In this case the disease of the sexual organs was the medium through which the cardiac disease produced the neurosis. The relatively favorable result is to be attributed to the removal of the cause of irritation in the sexual organs.

Much more important for us in this connection, than the local affections, are those causes which, without involving any particular organ, give rise to those neuroses that we are accustomed to call neurasthenia, hysteria, spinal irritation, etc. When we come to consider this subject, however, we will see that the sexual system plays an important part here also.

Hereditary predisposition is one of the important causes, and persons so afflicted may be divided into two groups. In the first group are those persons upon whose body there is nothing noticeable, though faulty nutrition and ill-formed bodies are often to be seen. In earliest childhood we find nervous and physical excitement, tendency to be easily frightened, starting in sleep, nocturnal enuresis, somnambulism, cold feet, convulsions, etc. There is often a ten-

dency to digestive disturbances, vomiting, headache, and even outspoken migraine. In the family are to be found nervous diseases, headache, epilepsy, chorea, hysteria and psychoses. One can be pretty sure that such persons will suffer at puberty with menstrual disturbances, especially with dysmenorrhœa.

The second group is characterized by signs of degeneration, atavism and faulty development. Alienists have known for a long time the connection between such anomalies and psychoses. Less known, however, is the connection with other nervous troubles, partly functional and partly anatomical—that is, having actual anatomical change for their basis. This matter is of importance to us because anomalies may be present in the sexual organs themselves either with or without similar changes in other parts of the body. It seems almost as if anomalies of the genital organs were especially common in cases of neuroses, as they are also in the male. Thus we are informed from reliable sources that cryptorchism and neuroses are often found together.

Among the causes of anomalies of formation may be named the influence of race, family, social conditions, and of climate. In Frieberg the frequency of these and their connection with neuroses and psychoses is very great, which is no doubt due to the frequent occurrence of cretinism. Where this occurs simple anomalies of development are not by any means wanting, and in a given case it is often difficult to determine whether the element of cretinism participates or not. It is possible that I overrate in consequence of my large experience in a certain locality, the importance of the connection between anomalies of development and the existence of the neuroses. Nevertheless, I have often seen this condition in persons coming from most distant places. Anomalies of development are to be found everywhere, and even cretinism is not by any means confined to mountain districts, and is to be met with in other localities oftener than one would suppose.

I am cognizant of cases of adactylia, syndactylia, and situs transversus of the organs, combined with neuroses similar to those which I have observed in the ordinary forms of abnormal development of the cranium, malformation of the cartilages of the ear, prognathism, etc. Anomalies of slight degree are easily overlooked and passed by; as a tusk-like projection of the front teeth, moderate prognathism of the upper jaw and defective development of the

lower one. Others are not noticed because they are concealed by the clothing; as connected toes, malformation of the external genitals, etc. Again others which affect the internal organs, are only to be discovered by a careful examination. Such as defects and rudimentary development of the vaginal canal, double vagina or uterus, many of the so-called uniformly contracted pelvis, infantile pelvis, etc., and separation of the epiphyses and diaphyses in almost all the long bones of the body. All these abnormalities are frequently to be met with in cases of idiocy or cretinism.

Of great importance for our subject are the congenital smallness of the blood-vessels and heart lesions, often united with rudimentary development of the sexual organs, and with chlorotic conditions. In certain cases one can not discover the cause of the neurosis in any anomaly on the individual in question, but must seek for it in some other member of the family. One has the neurosis and the other the deformity.

In a certain family, well known to me, there are to be found many cases of fingers and toes grown together, and in addition, idiocy, epilepsy, nervous headaches, and psychoses. These deformities, however, are not generally united with the neuroses. Thus an apparently normal and even well developed person will suffer from epilepsy, and another whose fingers are grown together will possess a nervous system that is apparently healthy. Still the affection often shows itself in the case of the latter, in that, even during the earlier years trembling of the hands and arms may be noticed when passing any object or during the act of pouring a liquid into a vessel. In spite of inter-marriage with healthy families, epilepsy and syndactylism are still to be found. Anomalies of development and neuropathies are almost always co-effects of the same cause.

The outspoken forms of idiocy and cretinism, which would otherwise have very little practical interest for us, are thus worthy of our consideration because they show the nature of the connection. Psychological defects and nervous symptoms, generally of a depressive nature, correspond to anatomical changes in the nervous centers which, as well as the external anomalies, have their cause in defective development; even the peripheral nerves show a tendency to the formation of neuromata.

Hence we infer that simple anomalies of development, not dependent upon idiocy or cretinism, may have the same cause as the so-called functional nervous troubles; only the

structural changes are so fine that we are not able to distinguish them. Still anatomical changes may sometimes be demonstrated. Thus a case has been reported where hysteria existed, combined with unusual structure of the gray matter of the brain, along with a double vagina and uterus.

There is still another relation which may exist between the anomaly and the neurosis. The latter may be caused not by congenital changes in the nerves but by a lack of development in some organ. The best known example, which Battey has given, is the defective uterus in cases where the ovaries are active. Although here the matter seems very simple and clear and the above mentioned casual relation certainly exists; still caution must be exercised in applying this principle to individual cases. When one reads the various histories of the cases, the idea can not be avoided that perhaps original changes in the nerve centers, or anomalies in the vascular system, (valvular lesions are not seldom noted) have assisted in the production of the phenomena. In truth, many symptoms have been looked upon as vaso-motor phenomena when in reality they were produced by congenital heart-lesions. The circulatory organs especially, must be kept in mind, for here anomalies of development are not infrequent and are united with chlorosis and anomalies of the sexual system.

Malformations of the external organs of generation, atresia vaginæ, or rudimentary development of the same, may give rise to nervous troubles, through futile attempts at cohabitation or by sexual connection in an unnatural way.

Finally, we see that anomalies of development may produce nervous disturbances through the mental sphere, and that the sexual organs may exert this influence in a high degree. The causes of acquired neuropathies are so numerous that we must content ourselves with considering those of greatest importance. In childhood, and especially at puberty, the foundation of the trouble is laid through lack of proper care for the body and insufficient exercise in the open air. Up to a certain point the tendency to dysmenorrhœa may serve as an indication for the disposition to nervous troubles and statistics show that the occurrence of dysmenorrhœa stands in inverse ratio to the time devoted to out-door exercise. It should be said, however, that excessive and fatiguing exercise, even in the open air, may have its disadvantages.

Chlorosis, combined with numerous nervous symptoms, is often seen in peasant girls as a result of continuous and severe labor in the field, along with exposure to the sun, insufficient food, etc. Moreover neurasthenia, spinal irritation, chlorotic symptoms, and even amenorrhœa or dysmenorrhœa may result from a single excessive physical effort, as, for example, a very long walk.

A very important part is played in this matter by education and occupation. Here statistics give us valuable information, by showing that the disposition to dysmenorrhœa differs in different methods of education. Of particular interest is the fact that the so-called ornamental education, including the study of the modern languages, music, painting, literature, etc., give particularly bad results. On the other hand, a system tending less to the development of the emotions and more to that of the intellect is found to result more favorably. It must also be remarked, however, that intellectual labor, too intense and long continued, as in the case of persons preparing for teachers' examinations, may often be very injurious.

I have lately seen a young lady, who became ill after a course of excessive study. She was pale, and suffered from loss of appetite and painful sensations in the lumbar and sacral plexuses, which several doctors had pronounced to be a result of some female trouble. A most careful examination under an anæsthetic disclosed no local trouble whatever.

Unsatisfied sexual impulse, or even ideal sentiments, make their evil effects felt—sometimes sooner, sometimes later—but generally between the ages of 24 and 30. Even the most blameless and modest individuals are not spared when they have become "old maids." Without the slightest suspicion as to the cause of the trouble, and perhaps completely ignorant of everything pertaining to sexual matters, they ascribe their troubles to other causes. The doctors also generally call this condition chlorosis. The principal symptoms are emaciation, pallor, sore, tired feeling in the back, cardialgia, depression, poor sleep, various menstrual disturbances, leuchorrhœa, etc. In such cases marriage is to be advised, or some fixed object in life, which will occupy the intellectual faculties.

The evil effects of onanism upon the nervous system have been sufficiently dwelt upon by other authors. We have here a direct local irritation, that may even lead to anatomical changes, especially catarrhs and hypertrophies, and in addition to excessive nervous and psychic excitation.

Imperfect coition and the use of means for the prevention of conception are extremely injurious, especially in the case of young women. This is all the more true when a mental factor is added, and the wife looks upon the affair as unjustifiable. Still worse is the effect of long continued and fruitless attempts at connection, in cases of rigid hymen, or impotence of the man. Not only severe neurosis, but also actual pathological changes in the sexual organs may be produced, partly from the local irritation, partly from the action of the nervous system.

The following case offers a most striking example of what has just been said: A lady strong and healthy, and whose family was free from nervous affections, married. The husband, who had always been a continent man, either on account of nervousness, rigid hymen or some other cause, failed to consummate the sexual act; nevertheless these fruitless attempts were continued for years. Gradually there appeared on the part of the wife, disturbances of the menstruation, spinal symptoms, asthmatic attacks, and finally hallucinations and conditions of temporary mental aberration. Various cures were tried, but all without result. There was pain in both inguinal regions and slight fever, and it was on this account that the case was finally brought to me. The uterus and vagina presented nothing abnormal except a slight catarrh. The ovaries on the other hand were each transformed into tumors, the size of a hen's egg, and the right one was adherent. Although I could find no changes in the tubes and the endometritis was slight, I still suspected that the disease of the ovaries had arisen originally from a salpingitis, which had extended along the mucous membrane till it reached the ovarian tissue. I debated a long time in this case before I decided to remove the ovaries. A cure by means of the operation alone was not to be expected, since great irritation of the nervous system was already present. However, the local affection was progressing, and I saw no prospect of successful treatment without first removing the local sources of irritation. I therefore performed the operation of castration, and found that both organs showed a high grade of cystic degeneration with proliferation of their stroma. The tubes which were also removed, were entirely healthy. In this case the functional nervous affection is to be looked upon as primary, and the organic lesion as secondary, and resulting from it. The interval is too short to give a final opinion as to the result, which up to date has been favorable.

Mental factors of an etiological nature are particularly hurtful when acting for long periods of time. Thus it will often be reported that the nervous trouble appeared after taking charge of a sick relative. A single shock, as for example fright, must be very intense to produce permanent nervous trouble, and I can not bring myself to believe in the frequency with which this is claimed to occur. In the action of mental causes, is shown the strong disposition existing in the female to sympathetic affection of the sexual system, or to speak more exactly, the genital nerves. A fright causes a general spasmodic attack, and at the same time a suppression of the menses. In nervous troubles arising from mental factors more gradual in their action, this disposition generally shows itself in the simultaneous appearance of spinal symptoms, the most various menstrual disturbances and fluor albus. The process will be favored when the mental evil has any relation to the sexual sphere, as for example in disappointment in love.

I was called some time ago to examine a young girl of good bodily development, who had complained for several years of headache, various menstrual troubles, and the most varied symptoms referred to the small of the back. The examination showed the genital organs to be in normal condition, with the exception of slight cervical catarrh and thickening of the parts. There being present a narrow vagina and rigid hymen, I could not but consider these changes as secondary. The family relations of this young girl were extremely unfortunate, and moreover a slanderous and utterly unfounded report had been circulated about her. I have no doubt that the wrong done to her feelings was the primary trouble which produced the local lesions in the genital apparatus.

The influence of acute infectious diseases, as diphtheria, typhus, scarlatina, as well as chronic troubles, severe losses of blood, and frequent confinements, upon the production of nervous troubles is well known. Equally familiar are the evils which our present social life offer—the over-filled, over-heated, and badly ventilated rooms, where so much time is spent; gas-light, cigarettes, and the evil effects of stimulants. Among my private patients victims of the morphine habit are not infrequent. The relation between a nervous trouble, produced by one of the above mentioned causes, and a simultaneous sexual affection is generally that of co-effect, both being the result of one and the same cause. It occurs not seldom that the nervous trouble is



the one first present, and that causes the organic and functional disturbances in the sexual apparatus. The darkest point in the whole matter is the *modus operandi*, whereby the neurosis produces the sexual affections. Here we must acknowledge the influence of the vaso-motor system and also of trophic processes. Moreover, the muscles and ligaments of the uterus undoubtedly play a part, and a not unimportant one.

There is not the slightest doubt that menstrual disturbances are not seldom produced by nervous influences alone, and there are good reasons for thinking that catarrh may have the same origin. In young girls, suffering from chlorosis and general nervous symptoms, there is often present a more or less severe catarrhal endometritis. It is extremely important to determine whether such a catarrh is the result of infection (using the term in its widest sense) nervous influence, or an altered condition of the blood. Only in the first case is an immediate local treatment justifiable, while in the others the main reliance should be placed upon more general measures, and one should think twice before beginning local procedures, which in such cases have special disadvantages. Moreover, the malpositions of the uterus, at least the flexions and the so frequently occurring retroversions, may find their explanation in insufficient innervation of the muscles, and in the direct or indirect trophic influences on the part of the nerves.

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## Hospital Notes.

### THE SURGICAL CLINIC.

#### SERVICE OF PROF. SHEARS.

At the close of the session Prof. Shears gave to the class a *résumé* of the work that had been done in the surgical department, of which the following is an extract: "I can not leave this subject until I have called your attention to the results of the operative procedures that you have witnessed in this clinic, for, after all, the results and not the number of operations made is the real index to the value of the work done. Of the patients operated upon before the class during the year not one has died in the hospital or after having left it, and not one but that has been benefited by the operation. When you remember that the list of operations includes lithotomy, exsections of the hip, the shoulder, and the elbow, amputations of the arm and the leg, extirpation of the rectum and the anus; partial excision of the ankle-joint; operations for hare-lip, varicocele, talipes, and a number of less important operations, you can readily see that the care which has been exercised in the preparation of patients and in the performance of the operations has been productive of the very best results. One of the most satisfactory points in the after-history of these cases has been the absence of destructive inflammation. In but a few cases have we had a temperature above 100°. Primary union has been the rule, suppuration the exception. I sincerely hope that the results you have witnessed have so impressed upon your minds the value of antiseptics in the treatment of wounds that, notwithstanding the difficulties which may present when you are removed from the conveniences of a large city, you will closely adhere to their proper employment.

## Miscellaneous Items.

The paper on the coexistence of scarlatina and measles, on page 95 of *The Clinique*, should have been credited to Dr. Otto B. Poppe, of this city.—*Apropos* of this item an interesting article upon the same subject from Dr. Rile, of Wilmington, Del., will appear in our next issue.—Dr. Pierre M. Hall, "82," has been appointed by the Governor a member of the State Board of Medical Examiners for Minnesota.—Our list of removals includes that of Drs. C. D. Warden from Carthage, Ill., to Marshall, Mo.; E. E. Nixon from St. Louis to Hot Springs, Ark.; and of Dr. R. C. Bain to his new office in Central Music Hall.—Dr. E. C. Faulkner, "89," has located at Seward, Neb., and Dr. T. C. Cochrane, "89," at Highland Park, Ill.—Dr. Margaret Hislop, of Washington, D. C., has been paying a pleasant visit to the old haunts at the Hospital and College and to her many friends in Chicago.—The forty-second annual session of the American Institute of Homœopathy will be opened at the Hotel La Fayette, Lake Minnetonka, Minn., on Monday evening, June 24th.—The twenty-fifth annual meeting of the Wisconsin Homœopathic Medical Society will be held at Racine May 28th and 30th.—The State Homœopathic Society of Nebraska meets in York May 14th-16th.—We are pained to learn of the death of Dr. L. J. Olmstead, the worthy son of our old friend Dr. C. C. Olmstead, from typhoid fever.—Its superintendent furnishes an item to the effect that, during the summer months the Hahnemann Hospital offers exceptional opportunities for the treatment of the general medical and surgical cases of a chronic kind which are crowded out in the winter and early spring, while the college is in session.—Dr. H. P. Holmes, of Sycamore, is on deck again after a serious illness.—The Methodists of this city and the Northwest have embarked in the enterprise of building the Wesley Hospital, which will doubtless be a grand charity one of these days.—Dr. T. C. Duncan and his friends are pushing the work of founding a Children's Hospital.—The Bureau of Gynecology will report at the next meeting of the Clinical Society, April 27th.—As usual there is no space for our Clinical Reviews, but possibly some of the neighboring journals, which are more roomy, might consent to publish them.

# THE CLINIQUE.

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VOL. X.]

CHICAGO, MAY 15, 1889.

[No. 5.

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## Original Lectures.

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### ICTERUS.

A CLINICAL LECTURE BY C. E. LANING, M. D., PROFESSOR OF CLINICAL MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

The patient I now present to your notice was first seen by you last week. Owing to my inability to attend my clinic, Prof. Fellows kindly took charge of it, and the case has already been diagnosed for you as a case of jaundice, and from the appearance of the patient it is evidently quite a severe attack. The skin of the entire body is almost of a dark bronze color, and the white color of the sclera has given way entirely to a deep yellow hue. On referring to the clinical record we find the history and symptoms of the case to be as follows :

*Case 512.*—For some time the bowels have been irregular, he has had a good deal of diarrhœa, the stools generally being yellow. The yellow appearance of the skin was first noticed about a week ago. Before this appeared he experienced a severe pain in the bowels which came on gradually, and disappeared after taking some medicine procured at a drug store. Has drunk much cold beer on a empty stomach; the pulse is rapid. His general health was good before this attack. The urine is very red. He has drank for the past year or more. The appetite is very poor; he has some nausea in the morning. Suffers from slight pain in the hepatic region occasionally, and is very restless at night. *Podophyllum* 3, four times a day.

This week he reports no improvement. It is not reasonable to expect any noticeable gain in so short a time, so we will therefore continue the same remedy for another week.

The next report was: Bowels constipated, stools of a whitish color, white coating on the tongue, bitter taste in the morning, food tastes natural, feels very drowsy most of the time, but cannot sleep, pulse too rapid and hard.

If we take into consideration all the symptoms of this case so far as elicited, there is every evidence necessary to establish the fact that the liver itself is a gland, a secreter of bile, and active enough. In this case the bile is formed by the liver from the elements contained in the blood, but for some reason it does not make its escape from that organ through its natural channels of exit. There are a number of lesions which might bring about this condition. Having positive evidence that the liver is secreting enough bile, but that on account of its being unable to escape into the intestines it is forced back into the blood vascular channels, what then is the object to be aimed at in the treatment? Podophyllum, and more especially podophyllin, is presumed to temporarily increase the power of the liver to secrete bile, and there can be but little doubt that it does so act. At once it becomes a question whether in such a case it is best to give a remedy that will increase the quantity of bile, of which there is already too much in the blood.

Before this question can be answered understandingly it is necessary that it be clear to you what such a prescription *can* do, and what conditions are to be overcome. Of course you know that the blood as it flows through the vessels exerts, according to the law of hydrostatics, a pressure upon their walls equal in all directions. You further know that this pressure *must* vary in accordance with the force *behind* the moving column of blood, and the resistance in part. Now if any of the watery or semi-solid constituents of the blood should pass out of it through the vessels into the surrounding tissues, it could not return into the blood-channels until the relative pressure within

and without was reversed. Thus, when a dropsical effusion occurs for it to be reabsorbed by the vessels that have thrown it out, the blood pressure at that point must be made less than that exerted by the surrounding tissues. In this way it is readily seen how a dropsical effusion is at least temporarily removed by remedies which stimulate the action of the kidneys. If the blood pressure is raised in one organ above that which is normal it will be depressed at some other point. Remedies which cause the kidneys to excrete more than the normal amount of urine in a given time do so principally by augmenting the flow of blood through those organs, and hence by raising the blood pressure in the renal region, this diminishes it at other points, and the watery portion of the blood also being thrown out more rapidly than it is supplied, assists materially in lowering the general pressure, and hence causes the effused fluid to be reabsorbed by the blood vessels; in short, to flow in the direction of the least pressure. An excellent example of this principle is seen in cholera, in which dropsical effusions that may have existed for months are rapidly dried up or reabsorbed, as well as the moisture of any abscess, ulcer, etc., which may be present, and all on account of the lowered blood pressure caused by the so-called rice-water discharges.

This may seem like a long digression and irrelevant to the case in hand, but it is not. I wish to teach you, as we proceed in our studies, as much as possible of the philosophy of medicine, that you may be able to solve for yourselves many of the problems which you are sure to meet, the answer to which you will not have been told by your teachers nor can you find them in your text-books. I wish you to know, so far as possible, what conditions you will have to overcome, and then you will be much better able to select the means with which to obtain the desired result. Too frequently the student comprehends a fact in so far as it relates to the case before him, but fails to apply it in the elucidation of another case, and this reminds me very much of a coachman my friend Prof. Hawkes once had. He fre-

quently had occasion, during a certain winter, to come and go on State street. The professor had often cautioned him to keep the cutter out of the car-tracks for fear of an accident, and he had carefully obeyed instructions. One day it became necessary for him to drive a short distance on Clark street. He had scarcely reached that street before the cutter was in the car-tracks, and in a few minutes more he was upset, and the vehicle was broken to pieces by the horse running away. When the professor was told of the accident he exhibited just a *little* of what he no doubt considered to be "righteous indignation," and said: "Have I not told you a hundred times to keep out of those car-tracks?" "Yes," replied the man with an offended air, "but you never said anything about the Clark street tracks." The professor was vanquished.

Let us now apply the principle enunciated to the case before us and see what light it will throw upon it. Bile is not preformed in the blood, and certainly not its salts, taurocholic and glycocholic acids. The bitter taste experienced in jaundice is due, not to the presence of bile pigment in the blood, but to taurocholic acid. We have reason to know that in this case that acid is present in the blood. Another unfailing evidence of it in such affections is an intolerable itching of the entire surface of the body, at times driving the patient almost frantic and compelling him to scratch himself until the surface is raw and bleeding, and often making it impossible to sleep day or night. I have purposely dwelt at length upon the fact that the liver secretes bile in this case, for only by knowing this to be so can we proceed to take the next step in unraveling the cause of the icterus. Not only are we sure that the bile does not pass from the liver into the intestines because we know that its salts and pigment are in excess in the blood, but also on account of the color of the stools. The presence of a certain quantity of normal bile in the intestine is necessary for the proper coloring of the stool. You must, however, bear in mind the fact that the bile alone does not give to the healthy stool its characteristic color, for although

it is freely mingled with the fæces, they retain their white color until they have passed into the colon. At this point the coloring matter of the bile, bilirabin ( $C^{16} H^{18} N^3 O^3$ ), is converted into biliverdin ( $C^{16} H^{20} N^3 O^4$ ) by taking on, as will be seen from the formula,  $H^2 O^2$ , the equivalent of peroxide of hydrogen.

We now come to the point where it is necessary to ascertain if possible why the bile passes back after being secreted from the biliary ducts into the blood. For some reason the pressure in the blood capillaries must be less than it is in the ductus communis choledochus, and on the principle that a fluid always flows in the direction of the least pressure, the bile re-enters the capillaries of the hepatic veins, and is hence carried into the general circulation, instead of making its exit into the intestines. This much is absolutely certain. What abnormal condition has then increased the pressure in the gall-ducts? If you will recall the fact that this man has been accustomed to drinking copiously of cold beer on an empty stomach, you will see that there has been an etiological factor with a powerful tendency to produce, first the chill, and afterwards a reacting congestion of the stomach and liver. Nothing could be much more conducive to a catarrhal state of the stomach, as well as of the mucous membrane of the biliary tubes. This condition once being established would clearly lessen the lumen of the biliary ducts, and increase the resistance to the passage of the bile to such an extent that it would find its way back into the vascular system more easily than it could escape into the duodenum. In such a case why should podophyllin and kindred remedies be given?

If you recall what I have told you about dropsical effusions and the blood-pressure, and then how remedies carry off the effusion by acting on the kidneys, I can easily make it clear to you how podophyllin might be useful in certain cases of jaundice, in which, however, it was not really the curative remedy. In the case of dropsy the blood-pressure in the kidneys was increased in order to lessen the resistance back of them, but had the resistance been in front of



them, or in the arteries, would not the excretion of urine under an increased pressure have overcome as much force in front of it as in the other case it subtracted, so to speak, from behind?

Increased secretion of any gland must be preceded by an augmentation of blood-pressure in it. Any remedy, therefore, which causes the liver to secrete more bile than is natural raises the blood-pressure in the gland, and hence offers a greater resistance to its return into the circulation, and of course will force the bile onward through the ducts that have been so occluded as to be impervious.

Giving remedies of this class for this purpose is not strictly homœopathic unless they are also capable of removing the catarrhal condition, or whatever may have caused the obstruction. Nevertheless, such treatment is at times scientific and rational, inasmuch as it is always allowable to overcome a greater evil by a lesser one, if possible.

In most cases of icterus the patient is drowsy almost all the time; the pulsations of the heart are slow. This patient presents the opposite condition, as he cannot sleep during the day, and is wakeful and restless at night; the pulse, instead of being as low as fifty or sixty beats per minute, as it most generally is, is going on as I have said, at the rate of 100 per minute. All of this is unusual, and shows the condition of the heart and vascular system in general, which must be corrected. The slowness of the pulse in icterus depends upon the action of the taurocholic acid on the inhibitory ganglia contained within the heart; and inasmuch as we know that this acid is present in the blood of our patient, there must be some undue stimulation of the cardio-excito-motor nerves.

Now let us sum up the case as far as we have analyzed it, and see what remedy is suggested. While overheated a portion of the organism was chilled, and this was frequently repeated; more or less sharp pains in the bowels ushered in the attack. Shortly afterward the skin began to assume a yellow cast, the stools became white and offensive,

the urine high colored, the tongue coated, the appetite almost disappeared, and the patient became wakeful and restless, with a rapid, wiry pulse. There is every reason to assert that there is an obstruction of the bile-ducts which cannot be overcome by the pressure of the bile. From the clinical history of the case there can be no doubt that the occlusion is at present due to a hypertrophied condition of the mucous membrane of the bile-ducts, which in turn is caused by the catarrh, back of which is a congestion of the mucous membrane.

If we take into consideration the etiology and the symptoms of this case, I think we cannot do better than to prescribe *aconite*, which we will accordingly do, giving it in the 3d on cones, two of them every three hours.

The next week the report was as follows: The bowels are now regular, and the stools are of a greenish color instead of white; the pulse has become stronger and softer, and now has 80 beats to the minute. He complains of great itching of the skin; the urine is more profuse and of a dark greenish-red color, and foams when being passed into the vessel; the appetite is better than it was last week, and the tongue has begun to clear up at the tip. He can scarcely sleep at night on account of the intolerable itching.

The symptoms this week show improvement in some respects, especially noticable in the lowering of the pulse, and the passage of some of the bile into the bowel, as shown by the change in the color of the stool. As would be expected there accompanies these symptoms of gain, a better appetite, and a still further clearing of the tongue. The itching of which I spoke last week, has appeared, and may even grow worse before it is better. When the bile has been retained in the ducts or the gall-bladder too long, the oxidation which should take place in the intestine, changing the bilirubin into biliverdin, occurs before it leaves the ducts or the gall-bladder, and hence, when it meets the fecal matter colors it green. In this patient we have evidence that while the bile does not make its exit from the liver rapidly, it does, nevertheless, enter the intes-

tines now, which it has not done since his illness began. When the bile remains in the ducts or the gall-bladder long enough to have changed the bilirubin into biliverdin, at the same time it always becomes more or less inspissated, and if this retention has been caused by a catarrhal state of the ducts, gall-stones are very likely to form. Having now reduced the resistance of the outward flow of bile, and at the same time knowing things are ripe for the formation of biliary calculi, it is time if it is possible to do something to ward off this undesired result. What shall that something be?

Before answering this definitely, I must give some of my reasons for suggesting such treatment, and show you what is advisable and best. In attempting to cure disease all physicians recognize the force of the aphorism *tolle causam*—remove the cause—but they differ in opinion as to what is the cause and as to the best means to remove it. It cannot be denied that the presence of bile in the blood, and its absence from the intestine, gives rise to certain symptoms of disease, and that, therefore, it is the *cause* of such disease as is manifested by these symptoms. But the bile in the blood, while a cause of disease, must be only a secondary cause, for it is not natural that it should be there, and hence the derangement of the organism which permits of its presence there, must be nearly the *real* cause of the symptoms that are only proximately due to the circulation of the bile in the blood. While this is all true, and while the only way to effect a cure is to remove the cause which prevents the bile from performing its natural functions, nevertheless, the cure may be hastened and unfavorable complications avoided if remedies are so used that they will hold in abeyance the secondary cause while the primary one is being removed.

In cases of pneumonia, typhoid fever and diphtheria, almost every physician, at a certain stage of the disease, makes use of means and remedies by which he hopes to avoid the threatened heart-failure. And this, too, while he is striving with other remedies to remove the cause of the

cardiac failure. In severe cases of peritonitis, or neuralgia, or in short any affection that gives rise to great and exhausting pain, the physician who does something to remove this great secondary cause, whether it be by the use of heat or cold, moist or dry, or some other means less harmful in its result than the pain will the most surely and speedily cure his patient. It must not be overlooked, that many times it is the effect so called, or secondary cause, that kills the patient. Unless something can be done to lessen the deleterious action of the secondary cause, the patient may die from an effect, while we are trying to remove the primary cause. A thorough knowledge of this subject, and the study of the remedies most useful and harmless for accomplishing this purpose is of great importance, and necessitates much patient study and investigation, but well repays the labor upon it. As occasion requires, I will explain this more fully, and give you clinical illustration of the truth and advantage of this branch of medicine.

In the case before us, then, we have as secondary causes or effects, free bile in the circulation, loss of sleep and much wear upon the nervous system as a consequence of the intense itching and irritation of the skin, due to the presence of taurcholic acid; and the imperfect digestion and assimilation which results from the lack of the proper quantity and quality of bile in the intestines, all of which have a strong tendency to reduce this patient, and to lessen his powers of resistance to the primary lesion that is back of all.

Now, what shall be done to diminish, to some extent at least, the activity of these secondary causes? If we can render the bile less liable to become inspissated and hardened, and thus not only prevent the formation of gall-stones, but also make it flow more readily through the partially obstructed gall-ducts, we will at once decrease the effects of all the secondary causes mentioned. *Sodium phosphate* has the power to do this in a marked degree. It may be given at such times and for such a purpose in quite large doses without producing any unpleasant, or indeed, noticeable

symptoms. It is unnecessary at present to go into the physiological action of this remedy, suffice it to say that ample clinical experience has demonstrated that it has this effect. We will let this patient have ten grains three times a day, and continue the aconite until he reports again.

The patient comes before you with some new light thrown upon his case. I took occasion to make a careful physical examination, which I have not had the time to do before, nor did it seem necessary, as there was every reason to believe the result would be negative, and so far as any light gained from the physical examination is concerned it has been. A slight hypertrophy of the liver was clearly made out, but it is merely hyperæmic, or congestive in character. Although repeatedly questioned as to the exact mode of the onset of the present attack, he never gave the history which he gave to-day, and which he assures me is the correct one. Instead of the pains which ushered in the difficulty being simply of moderate intensity, coming on gradually, they were most atrocious, and coming on with great suddenness, and radiating from the hepatic region, causing nausea and vomiting and a feeling of great debility, so that he, a vigorous man, was barely able to get to a drug store where he received an anodyne, that after a time gave relief. The pains returned the next day, though not nearly so severe. Immediately after this the icteric symptoms developed rapidly. The case now became clear; the patient most certainly passed some gall-stones, and partly as a result of this the catarrh which was, I am sure, present as a result of the indiscretions already referred to, became greatly aggravated. Indeed it is possible that the common duct was injured to such an extent by the passage of the gall-stones as to have become ulcerated in some portion of its lumen, and this has resulted in the formation of a cicatrix, which may occlude the duct to such a degree that the bile can never again have a free passage. This is not probable, but possible, and it should be taken into consideration in making a prognosis.

While in this case it is comparatively easy to make a diagnosis, sometimes there is more or less trouble in differentiating such a case, and others in which there is enlargement of the liver. The principal diseases in which this occurs are: cancer, cirrhosis, waxy liver, leukemic hyperplasia, fatty degeneration, thoracic lesions, as valvular diseases of the heart, mediastinal tumors, chronic pleuritic effusions, partial hepatization of one or both lungs, hydatid tumors, and hyperæmic and congestive hypertrophy, caused by the enlargement of the glands in the fissure of the liver, due either to scrofula or tuberculosis. On account of the jaundice occurring in some cases of atrophy it is necessary to be able to make a differential diagnosis between a case in which the jaundice is caused by an atrophic disease of the liver and one in which it arises from other lesions.

The patient continued the treatment for a week or so and improved slowly, but not satisfactorily. Having no decided symptoms for the continuation of the remedies he had received up to date, and having had excellent results in such cases when they had reached this point, with *nitro-muriatic acid*, I put him upon it, in the first dilution ten drops in a tablespoonful of water, three times a day. From the time he began taking this remedy he improved very rapidly, the stools assumed a natural color, the coating left the tongue, the appetite became good, the itching disappeared entirely, the urine cleared up, and he was in a short time discharged feeling perfectly well. This was January 12th, and I see, in referring to my clinical case-book, that on April 13th he returned to the hospital and stated that he "thought he was coming down with the same trouble again." Not having seen him, however, I know nothing as to the nature of the symptoms now present, but of course it would be nothing odd if he were to have another attack of gall-stones, his habits and all being taken into consideration.

## Clinical Society Transactions.

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JOS. P. COBB, M. D., SECRETARY.

APRIL MEETING. 1889.

The regular monthly meeting of the Clinical Society was held in Club Room No. 4, of the Grand Pacific Hotel, Saturday, April 27th, at 8:30 p. m. Thirty members were present, with Dr. W. S. Gee, First Vice President, in the chair.

This being the regular annual meeting, the Society proceeded to elect its officers for the ensuing year, with the following result: To fill the office of *President*, Dr. E. S. Bailey; *Vice Presidents*, Drs. Gee, Burt and Watry; *Secretary*, Dr. H. N. Lyon; *Treasurer*, Dr. W. M. W. Davison; *Executive Committee*, Drs. Hoyne, Shears, Gilman, Halbert and King; *Board of Censors*, Drs. D. S. Smith, Vilas, R. Ludlam, Jr., Leavitt and Arnulphy.

The remainder of the session was devoted to the following papers included in the

### REPORT OF THE BUREAU OF THE DISEASES OF WOMEN.

DR. R. LUDLAM, CHAIRMAN.

I. IS THE ARTIFICIAL RESTRICTION ON MENSTRUATION WARRANTED?—BY E. S. BAILEY, M. D.—In calling attention to this subject at this time, it is my object to elicit discussion, rather than to present positive assertions or to report clinical cases. While the question is not new, it seems to be one that is ever returning to the mind of the gynecological specialist, in the hopes that some method may be put into use that will assist in helping, if not in controlling, the ill effects of an abnormal menstruation. Can the artificial restriction of menstruation be used without danger to the health of the patient, and what methods are warranted?

The periodic function of menstruation is understood and described under the general headings, the time of the occurrence of the menses, their duration, the menstrual discharge, the quantity, the attendant uterine and ovarian pain, and the known idiosyncracies of the patient. It seems unnecessary to reassert here what are well known facts and phenomenon, to this audience, yet I do so simply that in the proper estimate of the question that the views presented may be from a standpoint that has been approved.

The duration of a single menstruation varies in individual cases, and in the same individual at different times. The average is from three to five days, it may be a week.

The quantity of blood discharged varies greatly, the estimate for the scanty flow being placed as low as two ounces, that of a healthy but excessive flow at eighteen ounces. It coagulates poorly on account of its admixture with mucus and the glandular secretions along the vaginal mucus membrane. If a coagulum does form, it is unstable, and readily liquifies again. The discharge is at first pale, in the middle deep red, and at the close of the period again pale.

Normally the menstrual discharge commences slowly, increases to a maximum quantity, and declines slowly. It is at first slimy, soon becomes thin, dark, sanguineous, acid in reaction, and its peculiar odor is due to the presence of fatty acids. It consists of blood, serum, ciliated and vaginal epithelium, pigment, disorganized blood corpuscles, and granular detritus, a debris of the uterine mucous membrane. The blood is in its nature venous.

The attendant pain is a variable factor, normal menstruation having, however, an uneasiness and discomfort, if not actual pain.

To encompass the irregularities of menstruation, a greater latitude is to be allowed before we may be forced to the conclusion of the existence of unphysiological or pathological conditions being present.

Do physicians as a rule keep in mind the simple physiological requirements of the function? There has been no lack of observation of the phenomena of menstruation, and these have led to a tolerably fair understanding of the processes as it occurs at the present, though it is possible that nothing is definitely known as to nature's original intentions in the establishment of such a flow. How much was intended to be wasted in this rythmical process? In the abnormal menstruation when does the natural cease and the disor-



dered begin? In the healthy and well woman the loss is readily tolerated, and that too at a minimum of discomfort. This class seem exempt from the ill effects of menstruation.

Where is the physician but knows that in some cases the menstrual loss is excessive and detrimental to the welfare of the patient, but yet feels perfectly powerless to aid. Is a perverted menstrual function to be allowed to perpetuate itself, simply because there are normal elements entering into some parts of the process? The class of cases referred to are often just the opposite of the healthy and strong. The toilers who work on uncomplainingly and carry an added burden that nature never intended. It is often the illy-nourished, the delicate, the anæmic, and those whose mental and physical activities are exciting, excessive and exhausting, that are called upon to sustain this excessive menstrual loss. The evils that are sometimes consequent upon the unnecessary waste are, in summary, brought under such names as neurasthenia, neuralgia, anæmia, with all of its neuroses and circulatory disturbances, chlorosis, uterine displacements, sub-acute inflammations and diseases of the uterine appendages.

Being convinced that the patient cannot afford these periodic losses, which aggravate the diseased conditions, does not the physician, by specific remedies, beg of nature to relent and spare the patient from further loss of animal fluids? Is it not the experience of practitioners, that there are pitiful cases of broken and debilitated constitutions, nervous patients verging on melancholia or a worse insanity, anæmic wrecks with bloodless skin and pernicious tendencies, whose every returning menstrual cycle is but another sentence to serve a variable quarantine of wretched waiting? Waiting for what? Possibly a tardy relief or temporary respite. Is nature demanding all of this penalty? Is not the normal function perverted in these extreme cases, where the period returns irregularly or too frequently, the quantity of blood lost being excessive even for a profuse flow, the character being hemorrhagic and clotted and arterial?

The point I wish to bring out is more especially this: that after the natural flow should have been ended, shall a hemorrhage be allowed to go on and on? Is this perverted function not to be interfered with?

Grant it that the carefully chosen remedy, selected by its provings or clinical usages, fail, and that tonics, hæmostatics, styptics, diet, rest, travel, etc., be exhibited

and enjoined, and yet the flow keep up the abnormal routine of excessive losses, is it an unwarranted boldness to interfere by operative procedures? Is it right to use the vaginal tampon and restrict the flow mechanically?

It has been proposed to use the term supplemental menstruation, when in connection with the menstrual flow hemorrhages take place at the same time from the mucous surfaces, as from the stomach, kidneys, bladder, nose, etc.

Would not cognizance be taken of such a loss? Is it well to regard a too profuse and too long lasting a flow, where it is the habit, and where the losses are excessive, as a supplemental menstruation also?

I will not pursue the inquiries further, upon the answers depends a deal of importance. It may be wisdom to have in reserve some remedial measures that may apply to the extreme cases to which I wish especially to refer. Could, in such cases, where depletion has already occurred not only once, but over and over again, the vaginal tampon, carefully applied, antiseptically fashioned and hygienically treated, produce a greater evil than the plan of non-interference? *Is the reduction of the blood loss to the minimum after the function has been allowed its fullest demands a rational procedure?* A few well known facts would seem to confirm this view, although I am not willing to assert its universal value nor the exemption from a possible harm. It is asserted that when the blood vessels are over-distended, as in proportion for the function, a slight flow gives relief from the pelvic congestion and the balance of the blood determined to the pelvic tissues returns to the general circulations from whence it came. "It is not the amount of blood in the body which conditions the amount of the engorgement, nor is it the amount of the engorgement that determines the quantity of the flow, it is the complete or rather the incomplete balance between the engorgement and the resistance to it, whereby the amount of the flow is regulated, and stands in direct relation to the tonicity or atonicity of the respective nerves and vessels. The resistance consists in the amount of obstruction placed in the way of the flow especially by the contractile power of the uterus itself."

Could not a tampon aid nature to regulate a pressure or tension that would subserve a health limit rather than create or assist in perpetuating an abnormal one?

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From observations on this subject, see Dr. Gehrungs' paper *American Journal of Obstetrics* for November, 1888, the *Medical Times*, June, 1888.

DISCUSSION.—DR. DAVISON: I have never thought of the feature of mechanically saving for the patient part of the blood lost at the menstrual period.

DR. KEMP: It is a new idea to me to tampon the vagina of a menstruating woman. The essayist says it has been claimed that menstruation is a function, the result of civilization. It certainly was mentioned in the Mosaic law.

DR. C. S. MACK: It would not seem right to check a discharge that has for its object the removal of deleterious matter, therefore, it would be important and perhaps difficult to say when this discharge ceased to perform this function and became hemorrhagic.

DR. LEAVITT: I have been deeply interested in Dr. Bailey's excellent report on a subject which rarely comes before a medical meeting for discussion. Reference has just been made to the menstrual blood, in terms which might lead some to infer that it differs in some essentials from that which is lost in case of hemorrhage. I think that Dr. Bailey was quite right in his description of the menstrual fluid. He explained its non-coagulability in general by the fact that there are mixed with it the vaginal secretions. But when it becomes a case of menorrhagia coagula do form in the vagina and are from time to time expelled. The same phenomena are observed in metrorrhagia. The explanation of coagulability of the blood lost in excessively profuse menstruation, is found in the fact that it flows so rapidly, and is so out of proportion in quantity to the vaginal secretions, that its character is not materially changed. It is a fact then, demonstrated time and again and easily demonstrable, that the blood lost in menstruation, when unmixed with the vaginal secretion and the uterine and vaginal detritus, is precisely the same as that which might be drawn from any other part of the body.

Now a word with regard to the proposition made in Dr. Bailey's paper, namely: That we tampon the vagina for the purpose of limiting the menstrual flow. This, as far as I know, is a comparatively recent proposition. Personally I do not take a fancy to it, not, however, because I do not

regard the restriction of the menstrual loss in certain cases justifiable, but because I look upon it as wrong in theory and unsafe in practice. During the menstruation there is a determination of blood to the pelvic organs, and especially to the uterus, whence comes the flow. This condition would not, of course, be altered by the form of treatment recommended, but we would only be damming up the blood in the uterine cavity, and thereby risking harm of a serious kind. For three or four years I have used vaginal douches of very hot water, for the purpose of controlling not only metrorrhagia, but menorrhagia, with very satisfactory results.

In several cases where the monthly flow has been so profuse as to produce exhaustion, and more especially where the health was already so deteriorated that much blood could not be spared, I have cut short the menstrual period in the way described, and that without ill effects. Only one injection is usually required; but the water must be of high temperature, and its quantity ample. Warm water will be of no service; but the thermometer should be used and the temperature run up to 120° or 122° F. If a thermometer is not at hand we may approximate these figures pretty closely by making the water as hot as the hand can possibly bear it. As water of this temperature flows over the mucous and integumental surfaces of the vagina and vulva it will feel scalding hot, but will do the tissues no harm. For the purpose of administering such a douche, the fountain or other similar syringe would better be used, though a perfectly acting bulbe-syringe will answer the purpose. The quantity of water should be from one to four quarts, according to circumstances.

Now when should such treatment be employed? The purpose for which I have recommended it is that of modifying the aggregate menstrual loss; for I should not fear to use it for the purpose of altogether preventing menstruation in certain diseased conditions where recurring monthly loss is seriously complicating ailments and gradually reducing vitality. For the purpose under present consideration, in

appropriate cases, I have instructed my patients to employ the hot water douche when menstruation has continued for a period of varying length, being guided, of course, by individual conditions and requirements. If the first injection does not greatly lessen, or altogether arrest the flow, two or more may be administered. I take exception to Dr. Bailey's recommendation on theoretical grounds, and am therefore liable to be in error. We may hear good reports from the practice at some future time; but I would rather have some one else experiment with tampons in these cases than to do so myself. I may feel more reluctant to plug the vagina than are some, and perhaps partly because, under *no* circumstances, have I yet found it necessary to do so.

DR. R. LUDLAM : If I am right, three points were considered in the paper under discussion : (1) The healthy menstrual flow may possibly become hemorrhagic ; (2) In order to save the patient's strength and to prevent subsequent mischief it is sometimes best to restrict that flow ; and (3) the query : Is it best to adopt Gehrung's method of packing the vagina in order to limit and to arrest the superfluous discharge ? The first two of these points have always been conceded by physicians, who have always acknowledged the necessity, in suitable cases, of trying to regulate the flow and to economize the patient's resources by preventing an unnecessary loss of blood. Even when the catamenial discharge was regarded as a *secretion* the incidental hemorrhage was believed to be harmful, and means were prescribed for keeping the flow within reasonable bounds. We have all been trying to fill this indication in various ways whenever it was necessary, and doubtless must continue to do so.

But the idea of caulking these patients with a firm tampon, regardless of the possibility of infection, or of inducing an hæmatocele by the regurgitation of the flow through the oviduct, or by the rupture of the ovarian veins, or of the revulsion upon the lungs, or the brain and the nervous system, or, most important of all, without reference

to the numerous causes of menorrhagia, is simply unwarrantable. In my judgment, we have better means that are already in hand, means that have been tried and are not harmful. Dr. Leavitt has mentioned the hot *douche*, and I can endorse what he has said about it, always remembering that it is too powerful an expedient to be used for this purpose without care and discrimination. We all know the effect of a strict quarantine at the month in the case of those who are likely to flow excessively; and the expedient of raising the hips and lowering the shoulders, not only to arrest a severe monthly hemorrhage from the uterus, but to avert a pelvic congestion that may result in the loss of blood, is as old as the hills, and is quite as useful in some of these cases as it has proven in hematocele after the manner advised by Dr. L. B. Couch. There are cases of this kind too, that will be relieved and the hemorrhagic sequel of menstruation properly disposed of by the simple expedient of keeping the rectum free and clear of fecal accumulation, and of a hemorrhoidal congestion that is incident to the monthly menses, and which predisposes the patient to this critical waste. It is sometimes quite as important to study the significance of the hemorrhoidal as it is of the hemorrhagic diathesis in its relation to profuse menstruation.

There is one class of cases especially in which for many years I have relieved this incidental hemorrhage by anticipation, and cured it too, without the tampon or anything of the kind. I allude to cases of spasmodic and obstructive dysmenorrhœa, depending upon a narrowing or closure of the internal os-uteri, with or without a flexion of the womb. These are the cases in which the struggle to bring on the flow finally induces a hemorrhage, so that the period which began as a dysmenorrhœa develops into a decided menorrhagia. The art of curing them consists in anticipating and relieving the stricture, so that the flow may come on promptly and naturally, without the contingent suffering or the consequent loss of blood. Merely to check the flow by the vaginal plug would not be, and could not be curative,

any more than to stop it by the internal use of cocaine, as one of my patients had done for many months.

But beyond and above all this, which is a matter of common experience, there is the cumulative evidence in favor of internal remedies as a means of restricting this accidental drain of the vital fluid. If there is anything in therapeutics upon which we may depend it is upon the efficacy of *Ipecac.*, *China*, *Nitric acid*, *Hamamelis*, *Trillin*, *Secale cor.*, *Sabina*, and similar remedies, where the flow is not due to an organic disease of the womb or of its appendages that requires surgical interference.

II. A CASE OF AMENORRHOEA. BY DR. JULIA M. ORR.—*Case.*—Miss Mollie E., a pale, slender girl of twenty-two, came into my hands February 22d, of this year. She had never menstruated, and complained of a good deal of pain in the left ovarian region, extending up over the hip and down the thigh. This pain came on periodically, lasting sometimes a few days, and again for a week or more, obliging her to flex the limb when lying down, and leaving her with a weak feeling in her side. It was severe and steady with occasional exacerbations of sharp, stabbing pain, and was accompanied by a slight leucorrhœal flow. She had headache nearly all the time, sometimes commencing in the back of the head, but more frequently in the temples and over the eyes—a dull, throbbing headache making her eyes feel heavy. The pupils were dilated, and there was a good deal of soreness in the back of the head, so the pillow hurt her at night. She rarely had backache, and there was no trouble with the digestive organs. For the past four years she has had ulcers on her legs. They come in clusters of two and three at a time, are about as large as a nickel, with raised edges, and are sometimes bathed in pus, again having only a bloody ooze. They go on in this way for months, then run together, and at last heal over to be replaced by another group. Her feet were cold, and she said her stockings were always cold and damp. She expected to be married in the early summer, and was anxious to get rid of her headaches and the sores on her limbs, but seemed rather hopeless about establishing the monthly cycle, as she had tried several physicians without success. She had always called herself strong and well, but the ovarian pain and headaches commenced

about two years ago, and were growing worse all the time. She is a clerk and stands all day, and sometimes her limbs felt weak and ached.

She was in the habit of drinking strong tea and coffee with her meals. I advised her to use milk instead. She did not care for milk, but thought she could take it hot, if good for her. I cut off pork, sausage, pastry and pickles, allowing her all the butter and cream she could make use of, and substituting plenty of lemonade for the pickles.

I put her on *Cal. carb.* 3x trit. and *Bell.* 2x trit. in alternation. The ulcers were cleansed carefully every night, bathed with hamamelis and protected from friction by a light bandage and carbolized cosmoline. After a few weeks hydrolein was added to her aliment, a teaspoonful after each meal. In addition to these remedies she had one treatment of electricity every week by general Faradization.

She was anxious to get well as soon as possible, and has been a very satisfactory patient, taking remedies and following directions regularly and faithfully. The dilatation of pupils, the headaches, and the soreness of the back of head disappeared during the first month of treatment. The menses appeared April 8th after eight weeks of treatment, preceded by a slight attack of ovarian pain. The flow was slight, lasting only for a day, but was unaccompanied by pain. The sores have healed, and she has gained in strength, weight and color, but will remain under treatment until the menses are thoroughly established.

III. CASES IN GYNECOLOGICAL SURGERY SHOWING THE IMPORTANCE OF A CORRECT DIAGNOSIS.—BY DR. R. LUDLAM.—The fact that this Society is exclusively devoted to the study of Clinical subjects, and that its membership is largely composed of those who are engaged in general practice is sufficient excuse for the avoidance alike of theoretical topics and of such a report of cases as would fail to interest those who are not specialists. So many snatch-papers will ripen and fall into the proceedings of our various societies within the next few weeks that we may well confine ourselves to practical matters, and keep as close as we can to the discussion of disease-problems and of the ways and means of relief for our gynecological patients. I therefore beg to present a few recent cases of gynecological surgery



which are possessed of points of common interest. The first of these was brought to me by our friend Dr. O. W. Carlson, of Milwaukee.

*Case 1.*—*A retro-uterine cyst of the ovary completely enveloped with intra-pelvic adhesions. Ovariectomy, drainage, recovery.* Mrs. —, æt 36, was married in April, 1880, miscarried without any known reason in April, 1881, and has not been pregnant since that time. She first menstruated at 14, but has always suffered considerably and flowed profusely at the month. When twenty years old she was accidentally thrown upon the arm of a chair and was so injured that, for a year or more, unless she was very careful, she was unable to sit down without pain. The periods had been regular, but there was always some membranous discharge. Her first physician was Dr. Small, who was called for the relief of her menorrhagia as she was passing through Chicago. Later she received local treatment at her home in Dakota for ulceration and anteversion of the womb, which treatment was repeated twice a week for many weeks. A physician in Minneapolis also treated her for a long time for "enlargement and misplacement," but she was no better.

A lady physician then tried for a long time to pass a sound and finally claimed to be successful in repositing the uterus with the result of inducing a very severe attack of peritonitis that lasted four weeks. Two years ago she was advised by still another physician to "come in occasionally and have the womb placed in position." For six months past she has had pain in the sacral extending to the pubic and vulvar regions, and for four weeks past, severe pains in the right groin.

March 18, 1889, she consulted Dr. Carlson, who decided that there was a growth of some sort behind the womb which had caused the symptoms of enlargement and displacement and that the case was one for operative interference.

I made an ovariectomy in this case March 30, 1889, at St. Mary's Hospital, in Milwaukee. Dr. Carlson, who is an expert in that matter, took charge of the anæsthetic (chloroform) and Dr. Belle Reynolds was my assistant. The tumor lay chiefly in the right side of the Douglas pouch and of the pelvis, while its upper margin was very little above the fundus of the uterus. It consisted of a sac that was distended to its uttermost capacity, and which, on

being tapped before it was detached was found to contain a pint and a half of a syrupy, dark, reddish brown, bloody-looking fluid. The entire surface of the cyst was covered with firm and very vascular adhesions. Indeed, these adhesions were so vascular that after separating them for a little way I adopted Terrier's expedient of averting hemorrhage by clamping the pedicle before the sac was separated. After this, the parts being blanched by hot water as we proceeded, the sac was released and the pedicle dressed in the usual way.

Great care was taken with the peritoneal toilet and a drainage tube was placed so as to carry off the serum that exuded from the torn surfaces. With excellent nursing and care in the after-treatment the patient's temperature reached 100° and a fraction but twice, and she has made a rapid recovery.

The points of clinical interest in this case are:

1. The importance of an early recognition of intrapelvic tumors, especially if they cause uterine displacements, or greatly increased suffering at the month, and if they are the source of declining health.
2. The unsatisfactory results and the danger from tapping such growths through the vaginal roof.
3. The value in certain cases of clamping the pedicle as a means of averting hemorrhage before breaking up the adhesions.
4. The value of the drainage tube in preventing sepsis by conveying away the serum that exudes from the torn surfaces which are left behind.

*Case 2.—Omental and enteric cancer with ascites. The exploratory incision*—This patient was brought to the Hahnemann Hospital by her physician, Dr. B. Banton, of Waterloo, Iowa, and the following are the chief points in the case:

Mrs. —, aged 44, was taken ill thirteen months ago with what was called peritoneal ovaritis. The abdomen became bloated and greatly distended and continued so until Dr. Banton was called. He pronounced it a case of dropsy, and about July 15 tapped her and drew off two pailfull of ascitic fluid. Since that time he has repeated

this operation four times, the intervals varying from seven to nine weeks, and the quantity of water taken being a little less than at the first. After the tapping a tumor can be felt, and it is evident that it has continued to grow, it being perceptibly larger after each evacuation than it was before. After recovering from the attack of peritonitis the stomach became very irritable and intolerant of food, but, under appropriate treatment that has very much improved of late. She still menstruates, but very irregularly. There is a suspicious lump in the left breast which she has had for five or six years.

As there had been a diversity of opinion among several physicians concerning the diagnosis in this case, and as she had already been carefully tapped five times without settling the question, Dr. Banton wisely counselled a resort to the exploratory incision. The trouble with the tapping was not in recognizing the ascitic fluid that was drawn off in such large quantity, but the difficulty was in deciding upon the nature and attachments of the tumor that was left behind,—whether it was solid or cystic, benign or malignant, or what organs were especially involved.

An explorative laparotomy was made at the hospital April 20, 1889. There was nothing peculiar about the incision except that the scars from the trocar-punctures were very vascular, and that the peritoneum was as thick and tough as a boot-leg. About two quarts of ascitic fluid were drawn off and the cavity was carefully mopped out. The uterus was in situ and slightly enlarged. The ovaries were also in position and were somewhat swollen. The tumor, the lower margin of which extended one-third the way below the umbilicus, was in the center of the abdomen, and was shaped like a very large, gnarly tomato. A large portion of its lower surface was formed of convolutions of the small and large intestines that were all massed with the diseased omentum. This tumor had no parietal adhesions but was firmly attached posteriorly. Between its lower margin and the superior strait of the pelvis there was a cavity that contained nothing but the descending colon, the rectum, and a large quantity of ascitic fluid.

The diagnosis being clearly established, it was evident that the tumor could not be removed. The wound was therefore closed, and during the week that has elapsed since the incision was made the patient has had no unpleasant or unfavorable symptoms.

*Case 3.—Operation for a recto-vaginal fistula, and failure of union because of the diabetic dyscrasia.*—Mrs. ———, aged 30, a healthy looking woman, was sent to the Hahne-mann hospital as a private patient for relief from a recto-vaginal fistula of three years' duration, and which had already been operated upon four times, but without a complete result. The opening, which was large enough to admit the passage of a wooden lead-pencil, was at the margin of the internal sphincter, and its border as well as the surrounding tissues had a healthy appearance. There had been no purulent discharge from it for some months, but the fluid fæces passed into the vagina quite readily. She had never been pregnant.

The rupture had resulted from an abscess, which was not caused by a stricture of the rectum.

March 2, I made the operation with the greatest possible care, and with Tait's method of splitting the margin of the wound, and with his incomparable suture. All the conditions were most favorable; the patient, who was extremely anxious to be rid of her infirmity, and who was now undergoing the ordeal for the fifth time, did exactly as she was told, and the nurse did not neglect her in any way. My other cases were recovering without any delay or complication in the adjoining rooms, and there was no apparent reason why she also should not get well at this time. But when I removed the sutures on the eighth day there was no sign of union. The tissues were healthy, there was not a drop of pus anywhere, and the wound looked exactly as when I had left it after the operation.

In reflecting upon the possible causes of failure with those who had preceded me, and in my own case also I recalled the writings of Verneuil,\* requested a sample of the patient's urine and found it to be decidedly diabetic. If this examination had been made beforehand, as it should have been, the operation would certainly have been postponed

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\* *Memoires de Chirurgie. Affections chirurgicales chez des sujets paludo-diabetiques*, vol. III, p. 608.

until the glycosuria was disposed of, and most likely a good result would have followed.

It is common enough to test the urine for albumen, and to examine the subject for the clinical signs of renal disorder before making a serious operation, but it is not advised that we shall look for any form of glycosuria as a bar to plastic operations about and within the vagina. I have taught my classes for the last ten years that the primary operation for a ruptured perineum would almost certainly fail if lactation had been established before it was made, because the mother would then be a physiological diabetic; and that the same cause might interfere with a secondary operation while she continued to nurse her child. But it is well enough to remember that certain fistulæ, like certain carbuncles and cutaneous affections, can not be disposed of while the urine is saccharine.

*Case 4.—Cervical fibroid with marked constitutional symptoms simulating cancer (with specimen).*—Mrs. —, aged 30, was sent to the Hahnemann Hospital by Dr. J. L. Walker, of Emmetsburg, Iowa. She had had no children, but about eleven years ago suffered an abortion at the fourth month, since which time she had not been well, having suffered from a decided prolapsus of the womb. Fifteen months ago she was examined by another doctor, who could find nothing wrong but "ulceration." Four months ago she discovered that something was growing on the neck of the womb. At first it was about the size of a "wart," but has since grown very rapidly. During those four months she has flowed very freely at the period, but has had a passive hemorrhage almost constantly in the interval. There is also a copious leucorrhœal discharge. As a consequence her feet and ankles have become dropsical, and her complexion is quite pale, sallow and anæmic. She is very weak, and her family and friends think her in danger of a rapid decline. Dr. Walker had seen and examined her but once when he decided that the case needed surgical interference.

Here is the tumor, which was removed from its attachment at the internal os-uteri two days ago. The Members will observe its size, its firm texture, and its well-marked capsule, points which, although it appears to have

been of rapid growth, show that it is not sarcomatous. The constitutional symptoms were evidently the result of the constant loss of blood and the drain of the vital fluids by the accompanying leucorrhœal flow—conditions that are attendant also upon malignant disease of the neck of the womb.

*Case 5.—A remarkable umbilical and peri-umbilical hernia.—Specimen.*—Mrs. —, aged 72, weighing 250 lbs., was shown to the class in my clinic December 3, 1884. She had an enormous abdominal tumor, which, when she sat down, projected beyond her knees, and which had been growing for about five years. Its origin could be traced to an injury that she received by being thrown forcibly upon the abdomen while in the horse-cars. On the first examination, which was not thorough, it seemed very like a compound cyst of the ovary, but it afterward proved to be a huge hernia. No operation was attempted, and she has since been chiefly in the care of Mrs. Dr. Reynolds, who made her as comfortable as possible with a suitable support, and by the use of internal remedies for the relief of incidental symptoms. After nearly five more years of suffering the poor old soul was finally relieved by death. An autopsy was made by my son and Dr. Hoey, of the Hospital, and this specimen, showing a large section from the abdominal wall with the intestines protruding through the umbilical ring, and an extra-abdominal tumor weighing forty pounds is the result. The patient's No. in the Case-book of my clinic was 17,320.

DISCUSSION.—DR. S. LEAVITT.—I would like to ask how and where this fibroid was attached?

DR. LUDLAM.—By a firm, broad pedicle at about the inner os-uteri.

DR. FELLOWS.—I have a parallel case to the one represented by the post-mortem specimen of an umbilical hernia. I do not know that it followed an injury, but nearly all of the bowels seem to be outside of the abdominal cavity. There have been several attacks of inflammation of the bowels during the last ten years, which have not been as serious as we might have expected.

VOLUNTEER PAPERS.—THE CO-EXISTENCE OF SCARLATINA AND MEASLES. BY DR. J. H. RILE, OF WILMINGTON, DEL.—THE CLINIQUE of March 15th reports some cases of this kind reported by Dr. Poppe. Those cases call to my mind one of the most curious and interesting cases which I have ever treated.

March 26, 1884, Mr. ——— sent for me to come and visit his two children, a boy and a girl, saying that he thought they were taking measles. They had been treated domestically for three or four days, and the eruption was not developing as it should. I pronounced the disease measles, and after the administration of my remedy, the eruption came out nicely. The boy made a good recovery. The girl's case, however, was more severe, but progressed nicely until on the night of April 4th I was called to see her, the father saying that she was much worse. I found the fever greatly increased, with sore throat, and a change in the appearance of the eruption. The father said to me: "Doctor, I believe this child has scarlet fever." I replied, "there is most certainly a change in the appearance of the eruption, but we will wait until morning when it will be more fully developed." The next morning, when I visited the patient, I found the symptoms of scarlet fever, and its eruption coming out nicely, and a sore throat which, during the next three or four days, assumed a phagadenic look about the base of the soft palate, so that it seemed to hang by a thread-like attachment. *Belladonna*, *Mercuries*, *Hepar* and *Kalium* all failed to arrest this condition, and I was beginning to despair of saving the life of my little patient. Delirium and a train of brain symptoms were appearing. A thorough physical examination discovered the involvement of the right ear and the mastoid process of the temporal bone, which condition led me to think of muriatic acid.

A close study of this remedy convinced me that I had discovered the similimum for my case. I accordingly administered the 3x dilution in water between nine and ten o'clock a. m., and, on calling again at three p. m., found to my great satisfaction, that my little patient's general condition was much improved, and that the dirty, eating ulcerated condition at the base of the soft palate had absolutely and entirely disappeared, leaving the surface clean and red and granulating.

In ten years of practice I have never seen such prompt and efficient action of a remedy as in this case. The child

continued to improve, desquamation ensued and was completed. About April 13th I was again sent for in the night, the child being reported much worse. I found it with a high fever, hot dry skin, suffused eyes, coryza, and a cough. The next day the eruption of measles came back, and after three or four days more this eruption had entirely disappeared with the other symptoms. The child made a good recovery, being left, however, with a persistent otorrhœa and a necrosed condition of the mastoid process of the temporal bone. I cut down upon the bone and evacuated some pus, and ordered injections of a solution of sulphuric acid and water 1 to 8, and give *Silicea* 3x internally. In a few days a good sized sequestrum came away, and silicea completed the cure.

Here, then, was a case where the stages of incubation of two diseases were probably simultaneous, the measles had the start, but the scarlet fever poison became the more virulent and overwhelmed the measles until it had run its course, when the measles naturally came to the surface again and finished its course.

Hahnemann, in the Organon, § 38, II, refers to the presence of two dissimilar diseases in the system at once, the weaker giving way the stronger, and the weaker again resuming its course.

This case has ever been one of peculiar interest to me. I have never seen one like it before nor since. I called in my preceptor, Dr. Kittinger, to see it, and he told me that he had never seen but one case similar to it during his experience of twenty-one years, and that was during the first year of his practice.

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## Hospital Notes.

### THE CLINIC ON NERVOUS DISEASES.

SERVICE OF PROF. H. B. FELLOWS.

IDIOCY, EPILEPSY, AND MALIGN HEREDITY.—*Case 15287.*—Otto L——, aged four years, came to the clinic April 1, 1889. His mother gives the following history of him: He has convulsions about two weeks apart, which nearly always begin in the right hand and arm, then affect the right side of the face and head, and then the right leg. Sometimes this order is varied by the spasms beginning in the face, and extending from the head downward. They are preceded for some time, at least at times, by a twitching of the muscles about the outer angle of the right eye. The spasms are followed by a deep sleep.

When he was about two years old he fell down stairs, rolling from one to another, until he got to the bottom. He did not seem much hurt at the time, and there was no visible bruise of the head. After this he fell from a chair, striking his head. This was followed by sleep, and when he awoke he had his first spasm.

He has never been able to talk, and makes no effort to. There is no paralysis about him, but he is very restless.

He is very much startled by noise, and always has been, even as a baby. The noise that water makes when running out of a sink would always frighten him. Thunder or wind storms seem to especially terrify him, although any sudden noise startles him.

His head is small, not being larger than what would be normal for a child half his age. There is no external evidence of any injury from his falls. When he was born the labor was severe, and the head was much out of shape, as the mother reports. Judging from her description of his appearance for the first two weeks after his birth, vitality must have been low at that time. It was two weeks or more before he took up life with the vigor of healthy children.

The mother is also very much frightened by storms, and during the pregnancy with this child suffered severely from this cause. She also reports that her mother received a severe fright from a tramp while enceinte with her, and the tradition in the family assigns this as the reason for her great trepidation during storms. Her other children have shown none of these peculiarities, though two of them have died; one other is living and healthy.

This case is evidently one of arrested development of the brain. Whether the falls which the patient received while still a baby, and the severe squeezing the head received during his birth, one or all, has acted as chief cause, it is perhaps impossible to tell at the present time. It is a fact, that such severe pressure on the brain as seems to have been present in this birth, is sometimes followed by damage to it from which it does not recover, and feeble-mindedness is the result. This condition is also frequently accompanied by spasms, usually of an epileptic type, and sometimes also by hemiplegia. Undoubtedly the predisposition to convulsions was either caused or increased at that time. This was further increased and rendered active by the fall from the chair. That the brain was already irritable is shown by the extreme sensitiveness of it to any unusual noise, as manifested by the starting and fright to which it was always subject. The brain cells did not show the stable equilibrium in their action that is usual in healthy brains; they lacked co-ordination. The fall upon the head produced a farther instability of action, which has its seat in the left hemisphere of the brain, as is shown by the spasms always beginning on the right side. The lesion is an irritating one, and not destructive; for it results in a sudden discharge of nerve force, a nerve storm, and not in paralysis. As the whole brain is more or less under the influence of the malign condition, what might in some cases be localized spasms, become generalized in this, and are attended by loss of consciousness.

Another thought suggests itself at this point in regard to the inability to learn to talk, that the brain about the

third frontal convolution was so damaged, or is left without development from the heredity, that speech becomes impossible. There is not loss of speech for it has never been able to talk, but a congenital aphasia. The discharging lesion in this case is so near to this region that this injury or defect may reasonably be supposed.

Another point of interest is the heredity in the case. According to the account of the mother of the child the disposition to morbid fear on the part of the grandmother was from an accidental cause. This descended to the daughter, the mother of this child, as a morbid fear of storms, and this to the patient even in a more excessive degree, the morbid fear including many noises which are somewhat out of the ordinary range of sounds, but in a marked degree storm sounds. Maudsley states that fright on the part of the mother may affect the brain of the child and thus be one of the causes of idiocy. In this child we see a degeneration of the nervous system going on until it has arrived at a point when this individual line of this family will die out, for such beings are usually incapable of continuing their race. They themselves usually die before adult age.

How far the mental condition of this child can be improved is a question only to be decided by the future. Where the defect only amounts to feeble-mindedness or imbecility, improvement to a moderate degree is possible, but the mind retains its childish characteristics, and often remains a moral imbecile to the last. The release of death is often a boon both to it and its friends. This is the more especially true in those cases, only too common, when vicious tendencies are developed. You will observe in this child a temper that will not for a moment lead you to believe him to be an angel.

We must try to stop these convulsions, and thus relieve the brain of so much of the incubus which darkens it. I wish we could tell the mother that the prospect for it was bright. Give it *Oenanthe* 3.

## THE CLINIC ON PHYSICAL DIAGNOSIS.

SERVICE OF PROF. B. S. ARNULPHY.

During the college year 92 cases of thoracic disease have been examined and treated in this special clinic. Some of them certainly deserve more than a passing notice. The following analysis will give an idea of the variety and interest of the work that has been done in this department. Among the patients treated :

**TUBERCULOSIS** easily claims pre-eminence, and of these there have been twenty-nine cases—eight of which were men, and twenty-one women. In fully one-half the cases heredity has been traced. In five cases contagion was ascertained; and it is highly probable in one case of tracheo-bronchial adenopathy. One of the patients was a stone-cutter. In one case only was the pleura found deeply involved—a girl of the Venetian type, aet. 12, showed signs of splenic tuberculosis, together with suspicious apices. Five incipient cases have been favorably modified. (*Sulphur, Arsenic, Calc. phos.*). Three old cases have had large cavities healed up. (*Kreosotum, Arsen., Calc. phos., Kali carb. Silicea*); and seven are still under treatment and improving. One case died and the others have been lost sight of.

**BRONCHITIS** : Two acute cases, six chronic cases; one of which had suffocative attacks; another exhibited signs of bronchiectasis, another of emphysema, and there were five other cases with suspicious symptoms.

**ASTHMA** : A male child aged 5 years, was cured with *Sulphur*. A woman aet. 45, was cured of a prolonged attack of more than two weeks' duration by *Glonoine*.

**PLEURISY** : One case with slight effusion, *Cantharis* cured it, and two cases of dry pleurisy. (*Capsicum, Arsen.*)

**PULMONARY CONGESTION** : One case in which it was due to excessive muscular exertion, cured by *Arnica*.

**HEMOPTYSIS** : Case of a young woman where blood-spitting occurred from traumatism on the chest was speedily cured by *Arnica*. An attack of hepatic colic followed and was removed by *Calc-carb.*

**SPASM OF THE LARYNX :** Case of young woman ; spasm probably reflex of some uterine trouble; improved by *Sepia*.

**MITRAL INSUFFICIENCY:** Eleven cases, three were men and eight were women. In three of the cases there was also stenosis of the orifice; and one case had marked dilation of the arch of the aorta; nearly all the cases showed hypertrophy of right heart, and bronchial symptoms, with a decided rheumatic history. *Naja* rendered good service.

**AORTIC INSUFFICIENCY AND STENOSIS:** Three cases, two men and one woman. One of the patients died suddenly of cardiac paralysis in the clinic room and under the eyes of the students. He had formerly been relieved of severe attacks of angina pectoris by *Oxalic acid*. *Plumbum* was given in these cases with good effect.

**AORTIC STENOSIS AND PHTHISIS:** Three cases, all women, where tubercular symptoms had developed as a probable consequence of the orificial coarctation.

**CARDIALGIA:** One severe case of anæmia, where murmuring could be heard all over the cardiac orifices. *Ferrum phosph.*

**FATTY OVERGROWTH OF THE HEART:** One case with characteristic symptoms, is now improving under *Phosphorus*.

**HYPERTROPHY OF THE HEART** from muscular exertion; improved by *Aconite* and *Arnica*.

**DILATATION OF THE RIGHT VENTRICLE:** Six cases, four women and two men, all presenting signs of chronic bronchitis. In two cases, more or less fatty degeneration. *Phosph.* *Strychnia arsenias*, *Hepar sulph.*, *Tartarus emeticus*.

**EXOPHTHALMIC GOITRE:** Three cases, all women, one of the cases a girl about 16, who had been considerably improved by *Kali iod.* and *Strophantine*, has suffered a sudden relapse.

**INTERCOSTAL NEURALGIA:** Three cases, women. One of the cases has been a sufferer for long years; the intercostal muscles of the left side have atrophied and the ribs are sinking in. Has inherited the disease from her mother. It rapidly improved under *Arsenicum* and *Kali mur.*

All these patients were the subjects of clinical study and were examined by the senior students under the immediate supervision of Prof. Arnulphy.

## Miscellaneous Items.

We are pained to notice the death of our old friends Drs. James B. Wood, of West Chester, Pa., and George F. Foote, founder of the Insane Asylum at Middletown, N. Y., both of whom were seniors in the American Institute.—The lady physicians of all schools of practice in the city have formed a Woman's Medical Union for the Advancement of Domestic and Public Hygiene.—Dr. G. B. McKnight has located at Ripon, Wis.; Dr. W. O. Cattron has entered into practice with Dr. S. D. Low at Pekin, Ill., and Dr. J. Murray Moore "has quitted New Zealand and has settled at 51 Canning street, Liverpool."—Just as this issue emerges from the press the Illinois State Society is convening at Sterling.—Bro. H. C. Allen, Chairman of the Railway Committee, notifies everybody that "Members and others attending the meeting of the American Institute at Lake Minnetonka, and paying full fare going, will be returned for one-third fare on presenting a certificate of attendance."—The annual report of the Calcutta Hom. Charitable Dispensary for 1888-89 is a very interesting document, and gives evidence of the excellent work that our friends are doing in that far-away land.—The State societies of Minnesota and of Iowa meet at the same time, May 21-24; the former in St. Paul and the latter in Des Moines.—The *Medical Investigator* is greatly improved under its new manager and editor, our good neighbor Dr. W. E. Reed.—Dr. W. A. Barker has changed his office to 1383 N. Clark street.—Our excellent anatomist, Prof. Baird, has been ill with pneumonia but is out again.—Prof. Fellows' report is next in order at the Clinical Society.—Dr. Priscilla G. Myers, of Aurora, Ill., has opened an Electric Institute for Women that we can commend and endorse.—Parts X, XI and XII of Wood's Atlas of Skin and Venereal Diseases fully sustain the char-

acter of that remarkable work.—Electricity in Facial Blemishes, by Prof. P. S. Hayes, has just been issued by W. T. Keener, 96 Washington Street, Chicago.—Drs. E. Z. Cole and C. S. Fahnstock, of Indiana, C. N. Hart, of Denver, Col., and S. D. Pollock, of Galesburg, Ill., are off for Europe on a “pleasure exertion,” leaving the rest of us to look after the Institute.—Saccharin proves to be an excellent antiseptic.—The Association of Seniors of the American Institute is indebted to its Secretary, Dr. Henry D. Paine, of New York, for an interesting account of the last meeting at Niagara Falls, 1888.—The Homœopaths of Indiana are to have charge of a separate Hospital for the Insane.—The New England *Medical Gazette* for May, always among our best exchanges, published quite an assortment of after-dinner speeches.—The whole school of medical tramps, sinners and sympathizers will be pleased to learn that, after all their bellowing, the Illinois State Board of Health has not gone by the board.—The papers note the sudden and accidental death of our good friend Dr. F. L. Vincent, formerly of Troy, N. Y.—A hot telegram announces that Dr. F. A. Gordon, of Sterling, has been elected President, and Dr. C. E. Laning Vice-President of the State Society.—Will the committees on Medical Literature in our various societies see to it that those who present papers for discussion have not stolen them from some known or unknown source, and that they are written and printed in good English?—*On dit* that we are to have another medical journal in Chicago!—The editor of the CLINIQUE herewith extends an invitation to the pilgrims *en route* for the meeting at Minnetonka to call upon their old friend and fellow-worker.

# THE CLINIQUE.

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## Original Lectures.

### *THE NORMAL PUERPERAL PULSE.*

A PAPER WRITTEN FOR THE ILLINOIS HOMŒOPATHIC MEDICAL ASSOCIATION BY PROF. S. LEAVITT, M. D.

It is a uniform practice among attentive physicians to keep their puerperal cases under close surveillance for a few days immediately succeeding delivery, giving careful attention to the rate of uterine involution, the orderly action of the various organs, and the state of pulse and temperature. The value of the clinical thermometer as a means by which to detect certain kinds of disorders in the system, can scarcely be over-estimated. In the presence of threatening symptoms, by its aid we are enabled to exclude certain simulated conditions, and brighten our prognosis; while again, by consulting it we are enabled to discover danger as it stealthily approaches. None of us would like to be deprived of this valuable instrument, and yet we must not, under all circumstances, put the same confidence in the data which it furnishes. In the puerperal state there are some who attach to the temperature curves far more significance than to the pulse; but I am not at present of that number. Without a careful study of the pulse in its physiological and pathological variations, and without some training in the detection of variations from a normal



type, we can derive but little knowledge from our frequent fingering of it.

During pregnancy certain important changes take place in the circulatory apparatus, in the vital fluid and in the nervous forces which govern them. In the blood, repeated examinations have disclosed a diminution in the number of red corpuscles, and an increase in the quantity of fibrin. At the same time there is a marked increase in the quantity of the fluid, somewhat in excess of the demands made by the augmented uterine vascularity. Other changes have been noticed, but they are of minor importance. This gives us then a plethora, so far as the mere quantity of circulating fluid is concerned; but an anæmia with respect to the red blood globules; while at the same time, and especially in the latter part of pregnancy, we have a condition of hyperinosis. Consentaneously with the increase in quantity of blood, certain cardiac changes take place with a view to greater capacity and power. The heart cavities become slightly enlarged, and the ventricles somewhat hypertrophied. This condition was first made known by Larcher, in 1857. Cardiac, like uterine hypertrophy, disappears after pregnancy has ended; but reduction is somewhat retarded by lactation. As the uterus augments in size, and the necessity for providing increasingly more oxygen for the fœtus strengthens, the vessels become multiplied, both in number and size, until at the close of pregnancy, this organ becomes truly cavernous, and contains a great quantity of the vital fluid. Meanwhile the woman has become a storage battery for the accumulation of nerve force, so as to be well provided against the exhausting effects of a difficult parturition.

Such changes as these have an important influence on the general circulation, which is exhibited to a certain degree in the radial pulse. Under these conditions in normal pregnancy, what characters would we expect to find in the pulse? First of all we would look after a good degree of arterial tension; secondly, for ordinary frequency, and thirdly, for fair regularity. These are the very pecu-

liarities which are ordinarily found. Dr. Mahomed was the first to call attention to these characteristics. Tracing No.



FIG. 1. PULSE IN A PRIMIGRAVIDA (AFTER BARNES).

6 is that of a typical pulse in the non-pregnant state, and No. 1 is a presentation of the normal curves in pregnancy, between which we discover significant differences. In sphygmographic tracings the more marked the plateau at the summit of the first ascending stroke, usually the more pronounced is the arterial tension. Care must be taken,



FIG. 2. PULSE DURING EXPULSION (AFTER LORAIN).

however, not to confound ordinary tension with the condition of atheromatous degeneration which produces a somewhat similar tracing.

After delivery, the condition in some respects is altered. The uterus after being emptied, contracts and condenses so as in great measure to reduce the quantity of blood circulating within its walls. It is this firm contraction of the organ in normal cases which prevents post-partum hemorrhage.

As the placenta is pushed off from the uterus by the shrinkage and contraction of the surface to which it is attached, solution of continuity involves many of the sinuses,

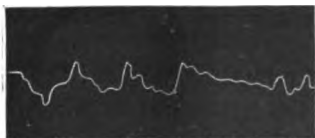


FIG. 3. PULSE IMMEDIATELY AFTER EXPULSION. (AFTER LORAIN.)

which would in every case result in serious loss of blood, were not only the mouths, but also the entire calibre of

these vessels nearly, or quite, closed by the uterine contraction. What hemorrhage we do have occurs chiefly during the interval between placental separation and expulsion, since thorough contraction cannot ensue while the uterine



FIG. 4. PULSE A FEW HOURS AFTER DELIVERY IN A PATIENT WHO HAD SUFFERED A PROFUSE, BUT NOT DANGEROUS, HEMORRHAGE. (TAKEN BY PROF. CRAWFORD.)

cavity is still occupied, even though not widely expanded. Closure of these large uterine vessels creates considerable



FIG. 5. PULSE SEVEN DAYS AFTER DELIVERY. (TAKEN BY PROF. CRAWFORD.)

change in the circulation, which, for a few minutes, sometimes for a much longer period, is felt by the heart and



FIG. 6. PULSE OF NON-PREGNANT WOMAN IN HEALTH. (AFTER BARNES.)

larger vessels. The tumultuous effect is well shown in tracing No. 3. Some blood is lost, but, in the average case,



FIG. 7. PULSE OF SAME WOMAN UNDER EXTREME NERVOUS EXCITEMENT. (AFTER BARNES.)

not as much as is now thrown out of the uterine circulation and forced into the systemic vessels. The result is increased arterial tension.

These are rapid and important changes, and must produce manifest effects upon the pulse. Immediately after

delivery there is pallor of countenance and diminished heat at the periphery, under which conditions, other things being equal, arterial tension would be further increased.

Again, under these changed conditions, what sort of pulse would we expect to find? Certainly not a rapid and compressible one, but the very opposite; and that is what we do find. Blot first called professional attention to the retardation and high tension of the early puerperal pulse. After labor it frequently goes as low as 55 or 60, and in some cases as low as 40 or 45. This it does in conformity with the law of physics which provides for an inverse ratio of frequency and tension. This we may regard as the normal pulse at that period in puerperality. In some we find a different state of things. I have occasionally noticed, soon after delivery, a very rapid and feeble pulse, but chiefly in those cases where an anæsthetic has been used to the extent of full narcosis. A similar state of the circulation is found after free hemorrhage; and, indeed, at such a time it would ordinarily be expected. However, the case from which tracing No. 4 was taken, suffered a great loss of blood post-partum, and yet this tracing, taken on the same day, disclosed a pulse which, in the non-puerperal state, would be regarded as about normal in form and frequency. Other conditions and circumstances are sufficient to establish a similar state, such, for example, as expansion of the arteries in certain parts of the body, through action of the vaso-motor nerves. It may also occur from vascular excitement. Some have attached considerable significance to a deviation from the normal slow pulse of the early puerperal state, claiming that a rapid pulse is indicative of threatened hemorrhage. There is a rapid pulse *following* hemorrhage, but not necessarily *preceding* it. "These notes," remarks J. Ashburton Thompson, in the *Obstetrical Journal*, volume V, page 285, "justify a contradiction of the bare assertion that a pulse which beats at or about 100 shortly after labor prognosticates inertia of the uterus." In the same journal, volume VII, page 556, Dr. M. M. Bradley gives his experience with reference to

this symptom in 300 cases, and says: "From these observations I am not inclined to attach much importance to the pulse rate, either as a sign of danger, or of post-partum hemorrhage." I notice that my good friend, Dr. G. R. Southwick, of Boston, thinks otherwise, for he says in the *Homœopathic Journal of Obstetrics*, volume VIII, page 176: "A pulse remaining at 100, and slowly rising, is often the fore-runner of hemorrhage." As an index of an enfeebled state of the general system, and hence of greater proneness to uterine relaxation, it may have some bearing on the prognosis. With a full, tense, and slow pulse, I should certainly consider the patient in *less* danger of post-partum hemorrhage.

As the normal puerperium advances, the pulse becomes a little more rapid, and loses some of its tension. Retardation and tension are not usually very marked after the third day, and when their disappearance is deferred we ought more attentively to watch our case. As late as the seventh day the pulse in the case from which tracing No. 5 was taken, still showed a very high tension. If the pulse loses these characteristics in a few days, and they subsequently return for a protracted period, the patient should be carefully watched for serious symptoms.

Continuously increasing arterial tension usually signifies either a chill or a state of constipation, and calls for appropriate treatment. Neglect of precautions may result in albuminuria and eclampsia.

Under the influence of the vascular excitement attendant upon the establishment of lactation, the pulse usually becomes frequent and soft. Vascular excitement and nervous excitement produce entirely different effects; the former diminishing, and the latter increasing, the arterial tension.

Within the first few days following delivery, with the vascular system unusually full, we can readily see what serious results would be liable to follow a sudden chill, a profound emotion and a variety of other occurrences. It is doubtless to this condition of the vascular system that inflammations involving vital organs owe their unusually

fatal results. Taking the slow, ample, strong pulse as a typical one in the early days of the puerperal period, it behooves us as careful obstetricians attentively to observe and investigate deviations from it. We cannot afford to neglect the clinical thermometer, but we may be excused from using it at every visit, provided we attentively regard the pulse. Serious symptoms will not be found in process of development, nor in full bloom, without there being some indications of them in the pulse. Whenever at any visit a change is discovered, we should not fail to consult the temperature, and make such other physical examinations as will be likely to throw light on its causes.

CLINICAL ITEMS.—Eustache reports the occurrence of a presentation of the shoulder thirteen times in the same woman.—Robin insists that biological chemistry proves that in diabetes, not only is there a decided increase of all the acts concerned in general nutrition, but there is a special excess of functional activity in certain organs which is most pronounced in the liver and in the nervous system.—Terrillon publishes a series of fifty laparotomies for tubal and ovarian disease, with thirty-four absolute cures; in ten the symptoms were improved; two persisted in menstruating; two were tuberculous but were benefited, and two died.—Grehaut & Quinquaud show that, contrary to the received opinion, there is a larger proportion of urea in the muscles than in the blood of a healthy person.—“Sanitas” is the best disinfectant for removing the horrible smell in cases of uterine cancer.—Openchowsky insists that digitalis acts only upon the left ventricle of the heart, and therefore the right side of that organ must be healthy, or it should not be prescribed. Besides, if the left coronary artery is diseased, the effect of the digitalis is null.

## Clinical Society Transactions.

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H. N. LYON, M. D., SECRETARY.

MAY MEETING. 1889.

The regular monthly meeting of the Clinical Society was held in parlor 44 of the Grand Pacific Hotel, Saturday, May 25, at 8:30 p. m., Dr. E. S. Bailey, the newly elected president, in the chair. Forty members and visitors were present. After some routine business, the Society listened to the reading of THE PRESIDENT'S ADDRESS ON

### *THE CLINICAL VALUE OF INSTRUMENTS IN DIAGNOSIS.*

BY E. S. BAILEY, M. D.

It was my privilege to be present at the first public session of the Clinical Society of the Hahnemann Hospital, of Chicago. That meeting was held in the large amphitheater of the college building, February 1, 1877, and I can distinctly remember the large audience that was present, and among other things the earnestness with which the charter members took hold of the clinical idea in medicine and resolved to make the formation of such a society a success. Section II of the Constitution which was discussed and adopted that night, reads as follows: \* \* \* "The object of the society shall be the study of clinical medicine and surgery, in all its branches; the collection of clinical records and experience within the hospital and college, and from the field of private practice; the accumulation and arrangement of clinical resources from all quarters; the analysis of obscure cases in practice, and through consultation and conference to secure the mutual benefits of professional experience to its entire membership." It was also agreed to by common consent that the character of the reports offered by the different bureaus should be uniformly

clinical as opposed to the merely theoretical or speculative. The idea prevailed that the real and the practical should characterize the work of this society. At no time during its history has it changed or varied from the initial idea, and the work still goes on. It is a pleasure to recall to your minds that after these twelve years of prosperous life the meetings are well attended, and the hour or two given to listening to the reading and recital of clinical cases, and their discussion, is still keenly enjoyed by many, and that the good accomplished has been far in advance of the wildest dream of any of the promoters of the plan of organization. This society is one of the living institutions of our school of medicine, and the audience addressed, and often as equally interested, is not only the one occupying these comfortable chairs, but many hundred others read and study the transactions with interest. Many take occasion to write their hearty approval of what goes on in this society room. I might multiply words in trying to tell you how in the past the work has been carried on, or what seems to be its success as foreshadowed in the immediate future, but I will not; preferring as I do to place before you something of a *résumé* of what has been done up to the present date.

This is the *one hundred and forty-seventh* regular monthly session of the society. In June, of 1880, and August of 1882, there were no papers presented or reports read, but with those two solitary exceptions, the monthly sessions have always been held, and the reports have all been printed. The average number of closely printed pages furnished by this society each month has been twenty-one, or what is equal to twenty-seven hundred pages in the twelve years of its existence. If this matter were printed on similar pages, it would fill four and one-half volumes of the "Transactions of the American Institute of Homœopathy." Is this not a subject of congratulation? Have we any rivals outside the National Institute? Our entire membership, resident and non-resident, is now *ninety*.

It will be remembered after referring to the above quoted section of the Constitution, that a portion of the work



allotted to the members can be accomplished in any field of practice. It is expected of those whose labors are confined to boundaries remote from this clinical center, that they feel the same freedom in calling for that discussion which throws light on obscure cases, or that they give for the benefit of others the results of their observations or the reports of interesting and rare cases. The cordial invitation to participate therein which has been so often given, is again renewed, and to make the old plan still operative, all members—non-resident and resident—will receive the same notice of the meetings, and the same invitation to contribute to the interest and success of the occasion. Let all the membership resolve to renew its effort of individually carrying a portion of the burden that ends in making a complete success of the work in hand.

It may never have occurred to some present that it has not been so very many years that such an undertaking of founding and sustaining a society of this kind could have met with any degree of success. The reason for it, if I read medical history correctly, rests in the fact that at one time there was very little accurate knowledge, in common, among practitioners. But few thought or prescribed alike. It was a sort of an experimental practice, and the profession differed very widely in what we now call the fundamentals of our system or science.

The dawn of what is sometimes called the clinical era in medicine, is of quite recent date. But let me explain, though it may seem presumptuous to attempt it in the very brief time allotted me.

Very material to the accuracy and truthfulness of a clinical report is the fact that upon its being stated, those who are listening or reading should be able to arrive at or sanction the conclusions drawn from the data given. In order to do this let us suppose a few cases: Take, for example, some disease of the eye. Ophthalmoscopy, in its wider meaning, includes whatever pertains to the objective examination of the eye. Where is there an eye specialist who would present a clinical report and would not base the

report upon a careful examination of the diseased eye with the ophthalmoscope, and with other instruments that might make the report accurate and intelligible? Yet the ophthalmoscopes, which have won a permanent place in the armamentarium of the ophthalmic practitioner, are all based directly upon the reflecting ophthalmoscopes of Helmholtz and Ruete. The instrument, as given by Helmholtz, in 1851, has been perfected as now used by specialists since 1869.

To Signor Manuel Garcia belongs the credit of having first demonstrated a practical means by which the interior of the larynx might be studied. In his essay, "Physiological Observations on the Human Voice," he described the respiratory and phonatory action of the vocal bands, and made some important explanations as to the production of sound in the larynx, and the so-called chest and head notes. Gracia's discovery was given out in 1855, and his laryngoscope, as afterward modified by Czermak, is the one in principle now in use.

Take another example. In the physical examination of the chest, for lung or heart troubles, while the stethoscope is not actually a necessity at all times, it is a valuable instrument. The cause of differences of opinion as to the value of this instrument doubtless lies partly in the difference in the acuteness of hearing, and the extent in the training, and partly as a habit. It is true, however, that a doubtful or half-heard sound can be brought out and appreciated by the stethoscope. It is an acoustic fact that sounds are better heard with two ears than with one, and virtually the double, or binaural stethoscope, enables us to place two ears on the chest at the same time. The value of the stethoscope for modesty, cleanliness and convenience, and for examining the supra-clavicular and axillary regions, which cannot be readily reached by the ear, are obvious and need only to be mentioned to be appreciated.

The earliest stethoscope was accidentally used, a roll of paper being in Laënnec's hand, he thrust one end against the chest of his patient and applied his ear to the free end.

Soon followed those made of wood ; the first dated back to 1843, but they were scarcely used until 1850 to 1852.

The sphymograph, with its wonderful exhibits, which at the present time are still enigmas to so many physicians, and yet are so full of intelligent prognostications, came in 1855, and is still begging for a place in common practice. Aspirators and aspiration for diagnosis came as late as 1869.

The æsthesiometer, that wonderful little instrument, and so simple, which gives the specialist in nervous diseases the measure of perception or sensation, is of recent or quite recent date, scarcely more than a decade.

The microscope, that instrument which has conquered the world of minuteness, has become widely known to scientists and to physicians within the past ten years, says Frey in his edition of 1880. He also says respecting the literature of the microscope and its work—I can refer you to the works of Vogel, 1841, Carpenter, 1856, Beale, 1867, as indicative of the time when the instrument was getting ripe for the general use to which it was destined among the profession.

What shall I say concerning the clinical thermometer ? Its history is obscure. A thermometer was discovered two hundred years ago. Over and over again was it ridiculed as having any place in the hands of a physician, as a guide in diagnosis or prognosis. It was not far from 1850 when Hunter first used it clinically to determine the heat of the part in a case of varicocele. It had a hard clinical birth, and it was not until near 1870 that its range or sphere of usefulness was established, and it was in 1881 that the self-registering instrument, as now in use, was successfully placed on the market.

In March, 1847, Flourens submitted to the Academy of Sciences, at Paris, a paper containing observations on the anæsthetic power of chloroform upon animals, and in the succeeding autumn Dr. J. Y. Simpson, of Edinburgh, introduced the employment of pure chloroform, as an anæsthetic, into surgical practice. In the same year chloric ether was

discovered and used as an anæsthetic. While not strictly instruments they have materially aided the whole domain of medical science in its clinical literature.

Very much could be said in praise of the clinical advantages derived from the discovery of the various speculæ used for examining the outlets of the body, such as Cusco's, Sims', Nott's, etc., and we know from the names used that they are all of recent date. The same would refer to the metallic sounds as well.

I would also mention briefly the great study of antiseptics as influencing the value of statistics and clinical records. The Péan hæmostatic forceps and the drainage tube are invaluable, yet of comparatively recent origin. What could I not say of the modern use of electricity? Thus I might continue to name instruments of great service to the profession, and not simply to those who use them, but from the uniform and universal knowledge of their importance, and the interpretation of the results gained, but I am content with those referred to as establishing the point in mind.

It seems that from the date of 1847 to that of 1857, and a little beyond, very many of the instruments now in common use were designed and perfected, and that the harvest of good results is now being gathered by all who read and study.

The reading of the above address was followed by the presentation of the regular

*REPORT OF THE BUREAU OF NERVOUS DISEASES.*

H. B. FELLOWS, M. D., CHAIRMAN.

THE ALCOHOL HABIT. BY DR. H. B. FELLOWS.—Habitual drunkards are by no means confined to any social rank or condition of society. In fact since Noah rendered drunkenness notorious by leaving us a record of his own condition, the human family has had plenty of followers

of him in this particular. The rich and the poor, the learned and the ignorant, have furnished the victims of this habit. It leaves neither palace nor hovel untouched by its blight. Brilliant intellectual powers do not hold the possessor from becoming an habitual drunkard, nor kind-heartedness prevent him from going into the gutter. Friends, family, bright prospects in life, great responsibilities intensify the picture of the degradation of him who surrenders to the baleful influence of the alcohol habit, but furnish him no direct assurance of safety from the so-called vice.

What then are the conditions under which this seductive power wraps its tentacles about man, like the Octopus, to compass his destruction?

The action of alcohol furnishes proof that physical means react on mental states. The mind of a man under the influence of alcohol is no longer like the same mind uninfluenced by it. The physical has changed the psychological, and how has it done it? The physical action of alcohol among its other immediate effects is directly on the cells in the nerve centers. In these persons there has been a physical change. This change, by the habitual use of alcohol, becomes a degradation. The power to act in a normal manner or up to a normal standard is lost. Such a change is produced as to result in a craving for more of the stimulant. Hence the appetite goes on increasing just in proportion to the degradation that has taken place. This condition results in instability and general weakness of the various voluntary functions of the brain, and, in fact, of the whole body until consciousness recognizes it as severe suffering which experience teaches will be temporarily relieved by a fresh dose of the same poison. This prostration and the vestige of the former experience left in the mind result in the cravings which constantly torment the sufferer. Out of these cravings, grown strong through habit, comes the impulse to seek again the relief. Under this impulse, ever increasing and strengthening, reason holds less and less sway over the actions, and thoughts which would restrain become dim and inert, until finally the man no longer gives them atten-

tion, and the impulse to drink holds full sway. Such in brief may be the history of any one who simply at first drinks more or less habitually.

So far we have presupposed a healthy brain without blot to start with. But in most cases there are hereditary conditions which cause this road to be the more certainly selected and the more speedily traveled. If the hereditary history of drunkards is looked up, there will, in the majority of cases, be found in the relatives, nervous conditions indicating instability of the nerve centres. The line of descent is not always from a drunkard, or even a habitual drinker, or a dipsomaniac, though often it is the case. The same law of descent that holds in other neuroses will be found to hold in this. An epileptic parent may have children, one of whom will go insane, another be a neuralgic, a third exhibit marked intellectuality, and a fourth become a drunkard, it being apparent that in all the children exists a morbid sensitiveness of nerve cell, resulting, in three out of four of the children, in a subversion of higher mentality and, as to all the children, in an entire difference of reaction to the objective of life. Also, disease or injuries of the brain frequently develop this habit of drink. No doubt the taste for liquor in some cases descends in a direct line, though sometimes skipping a generation to crop out in the next in the same form. And this is true of all other neuroses. Old Rip Van Winkle was reproduced in the young Rip.

A couple of years ago I had under my care a man of more than ordinary intellectual development, and kind and generous to a fault, who had inherited an unstable brain cell from his mother, and would have sprees lasting for weeks or months, during which he would throw to the winds every motive for prudence and restraint and all the force of his dear-bought experience, and drink, with no will power to stop it. It would be in vain to appeal to his reason or manhood, for he was under the domination of a morbid impulse as strong and imperative as any that could be exhibited in any one otherwise insane. In his case there was a direct descent of the peculiar appetite.

The following case illustrates the indirect descent of the appetite. It is taken from the hospital records of the Neurological Clinic :

Case 15,225; January 23, 1887; T. H.; aged 35 years. The trouble began fifteen years ago. The patient at first drank socially, which soon ran to excess. Since then he has not drunk steadily, but he gets on "sprees." Thesesprees have been growing more frequent, and last as long as he can get anything to drink. He has ruined his business several times, spending in some of his spreess amounts running up into thousands of dollars. After he has commenced drinking,—and even when but one or two drinks have been taken,—his memory no longer stores up recollections of his whereabouts or of what he has done. When he stops drinking he is very debilitated, and without appetite. He has then only a dreamy recollection of what has happened, and even this is so uncertain that he cannot make any statements on which he himself would place any dependence. He is forgetful and nervous, and unable to apply himself to anything. After a time his mind regains a fair part of its former clearness and he again becomes a good citizen, a kind father, an indulgent husband—until again the paroxysm for drink seizes him. Then, once more, the scenes of degradation are re-enacted—and no one more fully than he, during his sane periods, appreciates the horror of his life. This man's father he described as being very eccentric and irritable. In this case we see there was eccentricity in the parent leaving its impress upon the child, which resulted in a morbid appetite for drink, carrying him beyond the limit of self-control. Before the drinking would begin he always grew nervous and irritable, and evidently would lose mastery of himself, giving way to the morbid impulses which he could no longer control, though mentally fighting them,—sometimes for days.

Viewing this as disease he was placed under treatment and, we may hope, is rescued from a fate worse than death. Several times the old difficulty threatened but, with proper

treatment, each time the power was weaker and more readily overcome.

In the following case the heredity is unknown, but the appearance of the patient would make us think it to be nervous.

Mr. E. had been suffering much domestic difficulty. He appeared very quick-tempered and revengful. He had always drunk more or less—and generally more, according to his story—from boyhood. He had been drinking heavily at the time he applied to me for treatment, and though not exactly what in common parlance is called drunk, was seldom fully sober. He was put on treatment, and has taken but one glass of whiskey since, if I may believe his statement, and his appearance justifies the statement. His principal remedy has been *Strych. sul. 2x*, and *Strych. phos. 2x*, in one grain doses.

If excessive drinking of alcoholic stimulants is sooner or later a disease, it follows as the natural consequence that it must be a problem for the physician how it shall be treated. Dipsomania is now recognized in most works on insanity, but many writers still consider habitual drunkenness simply a vice until it eventuates either in *delirium tremens* or *mania á potu*. Until that time, the advice given is to "make an effort of the will." Good advice, surely, if drunkenness was only viciousness. Viciousness enough there is in many cases, at least in the early stages; but soon the will power is weakened and paralyzed. In the language of one who knows whereof he writes: "The habitual drunkard drinks not because he likes drink or likes to get drunk. He often detests the one and shudders at the thought of the other; but he drinks because he has an uncontrollable and morbid impulse to swallow intoxicating liquor. He may surround himself with every conceivable restriction, but in vain, as I shall show in the sequel, until at length the restless turbidness that is one of the punishments of habitual debauchery paralyzes all the efforts of a decrepit will and he ceases to think seriously on the subject. He does not dare to think on it, for if he does it produces a melancholy that sends him all the sooner to drink again. \* \* \* \* \*



"In 1875 I had dined with the Prince of Wales; in 1881 I dined with Duke Humphrey; in 1876 I lived in a mansion with spacious grounds, kept my own carriages, horses and servants; in 1881 I was a mendicant. The sole reason for this 'foul defeat and overthrow' was simply that I had become an habitual drunkard."

If the alcohol habit grows out of defective nervous stability, if the craving has a physical as well as a psychological side, it must fall under the physicians' care for its proper treatment. As long as the indulgence is slight, the stirring up of the will power may be sufficient to effect a reformation of the victim; but when the appetite has become so strong, and at the same time the will has become decrepit, assuredly some help from without must come to the sufferer's aid.

In the management of these cases it is well, in fact necessary, to get the patient to help you by a strong desire for a cure, if this be possible. In many cases, however, the mental powers are so weakened that very little help to the treatment can come from within the patient. In these cases a restraint of the person is necessary, a restraint so positive that not a drop of alcohol in any form may be had. This is not only necessary in the case of the habitual drunkard, but is even more necessary in those who go on "sprees" occasionally, the true dipsomaniac. It will be observed in these persons that before giving up to their desire for drink, they become restless and nervous, or irritable, or obstinate. This condition often lasts for some days before they give way to their debauchery. If they were wise they would allow some friend to put the most complete restraint on them at such times, and continue it until they are fully restored to their normal selves. During this time they should be under the watchful care of the physician as much as they would be if suffering any other form of delirium. They are much more liable to hurt either themselves or others, or both, than many who are put into the asylums.

It may be stated at the outset that there is no specific for this taste. In fact as irritation springing up in the system may cause the nerve cells to respond with a nerve-storm of the desire for alcohol, all such irritation should be sought out and relieved as soon as possible, and then the remedy against the taste will have the better power to act. The remedy which has acted best in this direction in my hands is strychnine; it has been able to so restore the stability of nerve action, that the desire for drink subsides. The dose I have used has been usually a hundredth of a grain.

Such other remedies must of course be used as tend to bring the subject into best health possible. Stomach, bowels, liver, kidneys must receive attention. Nor must the diet be overlooked, for under-nutrition will be very sure to bring on a relapse.

What then may we hope for in these cases? Some, I believe, will be cured so that years will elapse and find them still good citizens; others will do well, for a time, but the hereditary or acquired blot on the brain will be too deep to withstand the wear and tear of the world where life is a fight for everyone, and they will go down for good and all, or at least fall from grace occasionally.

One case is on record where a young man drank freely of cold water whilst heated. This caused an attack of fainting, and from this he recovered with a nervous system so deranged as to lead him to excessive drinking of liquor, although he was never given to this before. If this accident, seemingly so trivial, was enough to so change the current of his life, who can say that any one who has once been a victim may not become so again? We cannot make all the currents smooth.

DISCUSSION.—THE PRESIDENT: Has time verified the predictions for *cinchona rubra*?

DR. FELLOWS: It has proved of very little service. It may be required to bring up the tone of the tissues, but is not equal to strychnia as a remedy in my hands.

DR. DAVISON inquired if the same held true of the morphine habit?

DR. FELLOWS : The same condition prevails in all these cases, whether from morphine, hashish, etc.

DR. R. LUDLAM thanked the author for his valuable paper which was quite in a line with the advanced idea that dipsomania is a disease, or a dyscrasia, that comes within the scope of the physician. As a disease we should try to remedy it and to lessen the number and the severity of its attacks ; but as a dyscrasia we are not warranted in speaking of a radical cure of it any more than of cancer or of tuberculosis. The restraints that were advised in the paper just read were wholesome and requisite, but there was one safeguard that had not been mentioned. "No man," said an old and consistent temperance reformer, "is safe from the liability to relapse into the drinking habit so long as he continues to smoke. There are men who use tobacco who do not drink, but whoever stops drinking and means to keep his pledge must let his tobacco alone or the compromise will cause him to trip again sooner or later."

DR. GEE asked for the treatment in the acute attack.

DR. FELLOWS : I have nothing especial to offer, the subject of the paper being the "habit." The patient should be kept quiet and such remedies as *bell.* given in the earlier stages. Opiates must be used very carefully, if at all. Afterwards build up the system with beef-tea, milk, etc., and adopt a treatment to prevent a return. Stimulants should only be used as a last resort, when death is threatening from collapse.

DR. KEMP asked with reference to the value of the bromides.

DR. FELLOWS : They are not good in large doses.

II. CEREBRO-SPINAL MENINGITIS—By Drs. STEWART & STEWART, of Peru, Ind.—We were called on the 28th of last March to see a young man, aet. 27, who was said to be in a state of active delirium.

As he had spent the previous night at a neighbor's, and slept alone, we could get only a meager account of the commencement of the attack. We learned that he came home at 9 the next morning complaining of not feeling

well, and soon lay down ; said that he had had a chill during the night, and was quite ill. About an hour after he had lain down his mother found him unconscious. Soon after he was seized with an attack of vomiting, the ejecta being as "green as grass." His health up to the previous evening had been good.

On our arrival we found him in a comatose condition, from which he would arouse at intervals of ten or twelve minutes, utter some unintelligible syllables, froth at the mouth, and seemed by his motions to be going somewhere. The eyes were fixed and staring. At such times it required the united strength of two men to restrain him.

These paroxysms would last about five minutes, when he would again become quiet. The face was red, the pupils dilated, and there was a marked throbbing of the carotids. The temperature, taken in the axilla, was  $100^{\circ}$ , the pulse 66. Respiration varied from 18 to 30, reaching the latter figure during the convulsions. There was entire loss of consciousness, inability to swallow, and ecchymotic spots on forehead.

At this stage we were unable to determine whether we had a case of congestive chill, cerebral hæmorrhage, typhoid fever, pneumonia, acute mania, tubercular meningitis or cerebro-spinal meningitis, to deal with.

Belladonna was given every hour for five hours by means of the hypodermic syringe, when the patient was sufficiently relieved to swallow the sixth dose.

The following day Dr. Jordan, of Indianapolis, was summoned in consultation. We found the patient still delirious, and more restless than at the time of our previous visit. The temperature in the axilla was now  $101^{\circ}$ , the pulse had increased to 94 ; and respiration 35. A petechial eruption was present on the thighs, the shoulders and the chest. He was very thirsty, but swallowed with difficulty. The right knee was swollen, and the urine retained. We were now satisfied that the case was one of cerebro-spinal meningitis. The former prescription was continued.

Other symptoms of "spotted fever" developed in due time, severe headache, the neck drawn back almost at right angles to the body ; no movement of the bowels ; retention of the urine ; pulse slow and irregular ; the temperature at times one or two degrees below normal ; the lips swollen, and covered with an eruption which finally peeled off in large scales ; the tongue enlarged and covered with a dirty brown coating. Improvement was constant

from the first and he is now able to be about. The mind is clear, and the sight and hearing are good.

The *Bell.* was followed by *Arsenicum*, and later by *Cal. carb.* He is still taking the latter remedy.

III. A CASE FOR DIAGNOSIS.—BY DR. W. P. McCracken. *Case.*—A. L., æt. 18, a healthy looking young man, came in May 7, when he presented the following symptoms: Was very restless; could not sit still on the chair; his speech somewhat incoherent, as though the tongue was too thick, and words were slow in coming. He knew what he wanted to say but would place the words wrong in the sentence, and in answering questions would wander.

On questioning him he said that for about three weeks he had felt faint and dizzy in the morning after eating breakfast. His appetite was good, with a strong desire for coffee; he uses tobacco but very little; has no thirst. Is very restless at night; dreams and calls out in his sleep; is difficult to awaken; does not feel tired in the morning, although he has been very restless during the night. But what troubled him most was the condition of his right arm and leg, over which he had no control. There were frequent clonic contractions of the right side, the hand and foot being in almost constant motion, and if he tries to control them it only seems to increase the difficulty. Has trouble in picking up anything and cannot place it within three or four inches of the place in which you ask him to put it. Has had no pain in either leg or arm, and the muscles of face are all under control. There is a "numb feeling," he says, of the ring and little fingers, also about the elbow joint, and at times the foot seems asleep. He cannot distinguish points of instrument when separated one inch on the ulnar side of the hand, while the radial side seemed hyperæsthetic. Placing the hands on the knee supernated the right would be drawn to the ulnar side sharply and the ring and little fingers crooked. He kept kicking his feet and shuffling them all the time, and when walking stubs the right toe, and tires out on that side very easily.

His parents attributed the trouble to over-exertion while playing ball, but could find no history of lameness or soreness of the arm or side, and no chill or fever. Temperature normal, pulse 84. There is a discharge from the left ear at times that he has had for three years, or since he had

scarlet fever and diphtheria. The hearing in the right ear is normal, but in the left is only by bone conduction. *Zincum met. 3.*

Had hard work to get intelligent answers to questions, although when I have seen him before he seemed bright and had a good flow of language.

May 9. Yesterday p. m. he was unconscious for a time; got down on his hands and knees on the floor, and crawled around, but when spoken to about it denied it. Same remedy.

May 12. Not so restless, talks better and sleeps better. *Zinc. met.*

May 15. Not so well, feels dizzy, heavy feeling in the head, no headache and complains of slight pain in the right arm, following the course of musculo-spiral nerve. The appetite is not as good. *Macrotin 3.*

May 18. Feels much better. Same remedy.

May 22. Much improved as far as restlessness is concerned; can use the arm and hand better. There is a sore, stiff feeling in the shoulder and the elbow joint, also in the knee. Worse yesterday and to day (damp day.) Pain, at times sharp, runs from the middle of the arm to deltoid region, then again into the pectoral region. When out doors and walking, notices more trouble with his speech, but when in the house and sitting can talk without much hesitancy. *Rhus tox.*

DISCUSSION.—DR. DAVISON: Does not the longing for coffee indicate that there was something wrong with the liver? I have observed among the Bohemians that where this symptom is marked, the liver will be large and hard, and easily mapped out upon the walls of the abdomen.

DR. FELLOWS: Did the trouble come on suddenly?

DR. MCCracken: Yes; he had complained of being dizzy for several weeks, but the first objective symptom was a sudden loss of power while attempting to cut a piece of meat at the breakfast-table.

DR. FELLOWS: The sudden loss of power points to a brain affection.

DR. GEE spoke of the clinical significance of a suppressed eruption in kindred cases, and thought it a serious question whether the arrest of the discharge from the ear in the case reported, might not have had some meaning as to its cause and proper treatment.

VOLUNTEER PAPERS—MERCURIUS CORROSIVUS IN CANCRUM ORIS—BY DR. BELLE L. REYNOLDS.—In looking over the London *Lancet* of May 11, my attention was attracted to an article on "Cancrum Oris," by Dr. Murray, of the Liverpool Infirmary for children, in reply to one contained in the preceding number, in which he says that in the last twelve months they have had seven cases of this disease in the Infirmary. "An unusual number," and he observes that in considering the previous great mortality, he "was led to believe that if a more radical mode of treatment than usual were adopted, a better result might in the majority of cases be obtained." He then says: "Since forming this conclusion I have as far as possible completely excised the diseased tissues until bleeding occurred, and then applied strong nitric acid." "Of the seven cases above mentioned, four have completely recovered under this treatment, although in two of them the disease was extensive." The other three terminated fatally, there being complications. He also advised cleanliness, and feeding with a nasal tube.

In the CLINIQUE, Vol. 7, 1886, p. 157, Prof. Laning gives a clinical lecture on noma or gangrene of the cheek, based upon two (out of seven) cases which I sent him from the Home for the Friendless. In one of these children the tongue was nearly eaten off, and the whole of the cheek on the corresponding side was a mass of gangrenous tissue, the gums were so ulcerated that the teeth could be moved in any direction, and three of them fell out. The odor in all cases was sickening, and it required unremitting attention on the part of the nurse to avert the danger of auto-infection. Of the first seven reported the lesion occurred on the left side without exception, and four were boys. These children had all had scarlet fever or measles but a short time previous.

This disease sails under many names: cancrum oris, noma or gangrene of the cheek, malignant stomatitis, cancer aquaticus, etc., etc., but the symptoms are the same in all, and only vary in their intensity and malignancy. I am satisfied that prompt attention in the beginning has saved us from a repetition of the one case which proved fatal. In this the under lip and whole buccal cavity were involved, and the child, although nourished to the last with milk in large quantities, died of sepsis.

In Grave's Clinical Lectures, 1848, he speaks of cancrum oris as a disease greatly to be dreaded, but does not consider it contagious, and advises the application of

leeches to the tumefied cheek, purgatives internally, and washes of lime and soda. It is mentioned in some of the old works on practice as likely to follow cases of low typhoid, especially in asylums for children.

Another author has observed that some of the worst cases have followed whooping-cough, especially when the ulcer of the frenum was present, and that the disease seemed to spread from the ulcer. All agree that it occurs in children who have been poorly nourished and have been in unhealthy surroundings, and especially when they have had some of the eruptive fevers.

During the intervening years since 1886 we have had many cases at the Home; in fact, with a family of 150 to 180 children of all grades, and from all quarters of the globe continually under the same roof, we are rarely without one or more so afflicted. I have now nine cases to report which have been under treatment since the first of January, 1889, and all of which are cured, or nearly so. Of these nine, five are girls and four are boys. The youngest is three years, and the oldest is nine. The majority also were affected on the left side; in all the gums were badly ulcerated, and were the last to heal. Not one of the nine has had, since coming to the Home, any of the eruptive fevers, but one had whooping-cough previous to the appearance of the noma.

With the first seven cases my treatment was experimental, and although successful, a much longer time was required and the cases were more serious because they did not yield so readily to the treatment. I used *Nitric acid* 3 x dil. at first, followed by *Lachesis* or *Merc. Sol.*, as the case seemed to require, with the use of *Hydrastis* as a wash for the mouth. The time required for cure was from ten to fourteen weeks; a few cases longer. But during the last two years I have given *Merc. Cor. only*, in the 3 x trit., a powder three times a day, with irrigation of the mouth by *Hydrastis* tinct., one tablespoonful to a coffee-cup of hot water; to be applied directly and thoroughly to the diseased surface by a syringe, and at the last a small quantity to be swallowed. As a disinfectant, one or two drops of carbolic acid are added to the preparation. This is applied three times a day in the worst cases, and the mouth frequently rinsed out with alcohol and water. From six to eight weeks is all that has been required in these cases.

The digestion is generally good, although little meat is allowed, the principal articles of diet being milk and meat



broths, and all fruits in their season. The patients complain of very little pain, and have rarely, with one exception, been confined to the bed.

That it is infectious seems to me probable, as it occurs when brothers or sisters sleep together, while children that are isolated are not affected, **except when as a sequel of some eruptive fever.**

The literature is mostly confined to the German, with the exception of Meigs and Pepper, and an article by Dr. Clarence M. Conant, in Arndt's *System of Medicine*, Vol. I., p. 562; but the latter does not mention *Merc. corr.* as one of the remedies used.

I have found but one or two physicians who could give me any hints from their experience with such cases, as it rarely occurs in private practice. Probably if reports could be had from other institutions where a large number of children are housed, we might be able to do even better than this.

A CASE OF UTERINE HYDATIDS, WITH SPECIMEN.—BY DR. W. T. KILE, of Atlantic, Iowa. *Case.* Mrs. J., æt 32, the mother of four children, the youngest of which was two years old. I first saw the patient December 26, 1888, at 1 p. m. Found her in great distress with labor-like pains, and but little flowing. She did not report any miscarriage and had not had any pain until that day, but said that she “had felt an enlargement in the region of the womb, which seemed to move, and that she had not had good health for a year.” She went 150 miles south on a visit in October, 1888, and while there her regular monthly flow occurred, and that flow had continued ever since more or less profusely. She was pale and bloodless, and very much debilitated. I gave her belladonna, and directed her to keep quiet.

At 5 p. m. of the same day I was called again and found her flowing profusely. The hæmorrhage was hastily controlled with a tampon and by raising the foot of the bed. She was very much exhausted, but rallied by the use of remedies and stimulants. Her husband showed me a large hydatid mass that had been discharged just previous to my arrival—about two quarts in quantity, with some blood-clots attached.

The tampon was changed daily. On the second day after this I found some of the growth remaining and attached near the fundus of the uterus. I separated a portion of it but as the hæmorrhage soon began again, we ceased and reintroduced the tampon. The flow was controlled with remedies and the tampons, but she became weaker from day to day, and died on December 30, following.

CORRESPONDENCE.—IS THERE A PANCREATIC TONGUE?

*Mr. Editor:* Knowing your deep interest in any diagnostic sign I wish to call your attention to a peculiar appearance of the tongue that seems to me diagnostic of disorders of the pancreas, that auxiliary organ whose digestive scope we are not the most conversant with. It is a peculiar greasy coat on the tongue. The coat is not heavy, but *thin, white* and *glistening*. There is usually no change in the size or shape of the tongue. The general symptoms are those of chronic dyspepsia (so-called). Fats are especially repugnant to patients with this peculiar tongue. I suppose it might be called a pulsatilla tongue, for that remedy acts magnificently in these cases. It is not a potash tongue for that is flabby, broad, and the coat, although white, is thicker and fissured or broken. Practically it is a greasy tongue. Fats being eschewed there is none of the fatty acid regurgitation that gives us a scalded tongue. A milk tongue would perhaps be the best name to give it. The pathology is evidently a pancreatic hyperæmia. If you or any of the readers of the *CLINIQUE* confirm this impression I should be pleased to record it in the forthcoming edition of my work on Diseases of Children.

100 State St., Chicago.

DR. T. C. DUNCAN.

## Clinical Reviews.

ALCOHOLISM AND CRIMINALITY—THE MEDICAL TREATMENT OF DRINKING AND DRUNKENNESS. BY DR. GALLAVARDIN, of Lyons.\* *Apropos* of Dr. Fellow's excellent paper on the "Alcohol Habit," (see page 221,) we cannot forbear to give a brief notice of this new book just issued by Bailliére et Fils. The moral and the political aspects of this question have been often discussed at the expense of its medical relations. The doctors have always had to do with the effects of Intemperance, as they have always been called upon to treat other diseases of the mind that have their root in some inveterate dyscrasia. Hitherto the trouble has been that the application of a wholesale method of physical and moral restraint, as well as of medication, has been depended upon to overcome the habit and to cure its effects. But, now that our neurologists are discriminating its nature and learning that, as much as in any other disease of a similar kind, its special treatment lies within their province; and now that the alienists of our own school, in the various insane asylums especially, are demonstrating the wonderful effects of fitly-chosen remedies in obscure affections of the brain and the nervous system, the case is changed and we may reasonably hope for better results.

In this view of the subject the aforesaid report to the Clinical Society, and the appearance of this clean and comely little book, are timely and suggestive. They lie quite within the clinical horizon and may help us all to help those who suffer from this unfortunate infirmity. Dr. G.'s volume contains many suggestions of a practical sort. Not only does he show the necessary relation between crime and inebriety, but he emphasizes the fact that insanity and kindred diseases are in ratio with the drinking habits of a

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\* *Alcoholism et Criminalité, traitement médical de l'Ivrognerie et de l'Ivresse par le Docteur Gallavardin, de Lyon, Paris, 1889, pp. 226.*

country or of a community. A very practical application is made of the rule that drunkards who as yet have only mental symptoms are the most responsive to the proper homœopathic treatment, and that, therefore, they should not be turned away or neglected. We should cure them, if possible, before there are any secondary or settled organic lesions.

The author recognizes two varieties of cases, (1) the acquired form, which is the more easily cured by remedies chosen upon individual indications, and (2) the hereditary form, in which the child was begotten while the parents were intoxicated, or in which the parents are of intemperate habits. For the relief of the more common and frequent symptoms the following remedies are named in an available repertory, at page 89:

For the convulsive form of drunkenness, with contusions of the extremities, the trunk and the head, *nux vomica*, *belladonna*.

For jealousy, *nux vomica*, *lachesis*, *pulsatilla*, *staphysagria*, and especially *hyoscyamus*.

Mania for striking, *nux vomica*, *hepar sulphur*, *veratrum alb.*, *hyoscyamus*.

Mania to destroy everything, *veratrum*, *belladonna*.

Mania to kill others, *belladonna*, *hepar sulphur*, *hyoscyamus*.

Tendency to suicide, *arsenicum*, (by poison, the dagger, hanging, or throwing himself beneath a wagon,) *nux vomica*, (by the dagger, by fire-arms, or by drowning,) *belladonna*, (by poison, or hanging, and especially by throwing himself from a height.)

Excessive gaiety, *opium*, *coffea*.

Plays a comedy, *stramonium*, *belladonna*.

Unusually intelligent, *sulphur*, *calcarea carb.*

Stupidity, *opium*, *stramonium*.

Sleeps, *opium*, *belladonna*.

Impossible to awaken him, *nux vomica*, *coffea*.

Talks incessantly, *lachesis*, *causticum*, *hepar sulphur*, *petroleum*, *magnesia carb.*

Crying, *stramonium*, *hyoscyamus*, *ignatia*, *causticum*.

Insulting, *nux vomica*, *hepar sulphur*, *petroleum*.

Snarling and fault-finding, before, during and after the fit, *hydrastis can.*, *nux vomica*, *causticum*, *lachesis*.

Disposition to go completely naked, *hyoscyamus*.

Excessive genital excitement, *nux vomica*, *china*, *phosphorus*, and especially *causticum*.

Doing and saying what he would not have done or said before being drunk, *lachesis*, *belladonna*, *sulphur*.

For the cure, or to prevent the development of hereditary drunkenness, the author prescribes a routine treatment which may take two, three or more years, and which consists in giving thirteen remedies; one after the other, for so many days each. Briefly these remedies are *sulph.*, *nux v.*, *ars.*, *merc. viv.*, *opium*, *lach.*, *puls.*, *petrol.*, *con.*, *caust.*, *magnes. carb.*, *staph.*, and *calc. carb.* Of the remedy a single dose is given in the 200th for a young man beyond the age of 13 or 14 years. The children of drunkards below that age are very sensitive, and are therefore given the same remedies in the 30th dilution; but in them each medicine is continued for only half the length of time required for the adult. Thus sulphur is continued for twenty instead of forty days, and petroleum for thirty instead of for sixty days, etc. At page 96 we read:

"I am sometimes asked how soon I can cure such a drunkard, and my reply is that it is impossible to say. For among these cases there are no two of them that are alike in form, temperament, character and susceptibility to the action of remedies. For this reason each will see, think and act for himself, and each must be treated accordingly. It is especially the mental treatment that the physician should regulate most carefully." Again, "Among the effects of medicines upon drunkards we not only observe the greatest variety of results, but often real contradictions. For example, under the influence of *nux vomica* 200, a man who had become drunk from taking a glass-full of wine could drink several of them without feeling it; while another person who required two bottles of wine to make him drunk, could not bear a single glass of the same wine. After having taken this remedy without knowing it, another toper had no more desire for wine when invited to drink; and in a fourth the remedy caused such an aversion to it that he no longer took anything but pure water, or sugar-water. One of them who had ceased to be a drunkard kept his other characteristics; while another who was

cured of the habit was no longer jealous or unkind, but became amiable and useful in his family relations."

The text gives a considerable number of cures that have been effected by physical and moral means, and by a few or many remedies in the crude and in the medium and the higher potencies. Some of these have been selected from the various authors who have written upon the subject, but the most of them illustrate Dr. G.'s large experience and wonderful success with the treatment already indicated. There is also a keen discussion of the different methods of treatment that have been proposed from time to time, and with which the literature of the subject abounds.

Our readers are free to test the plan of the author and to learn for themselves whether it has any real clinical value. It hardly seems as if the "Gin Juggernaut" could be stopped in its horrible course by any such delicate means, but it is possible, and we must not despair while the black cloud of desolation covers the country and the fair face of this beautiful world.

AMERICAN RESORTS ; WITH NOTES UPON THEIR CLIMATE.  
BY BUSHROD W. JAMES, M.D., etc., etc. Philadelphia and London, 1889. F. A. Davis, pp. 285. This is a book that every physician whose patients need a change of air and of scene, and of doctors too, should buy, peruse, and consult for the benefit of his own reputation, and the welfare of those who take and pay for his professional advice. The only fault to be found with it is that it reads like a Tourist's Guide, is too full of geography, contains too little concerning the real choice of a resort for invalids, and does not say a word of Chicago as a delightful summer resort.

## Miscellaneous Items.

In Dr. Lyon's article in the April No., page 157, read *urea* for urine.—Dr. A. C. Hall, Jr., '89, has located at Grand Crossing, Ill.—Prof. Hall's office hours are now from 9 a. m. to 1 p. m., and those of Prof. Halbert from 8 to 9 a. m., and from 5 to 7.30 p. m., at the old address, 2400 Prairie avenue.—Dr. C. F. Ely has removed his residence to 149 Dearborn avenue.—Dr. Belle L. Reynolds is at her down-town office, Stevens Building, 24 and 26 East Adams street, from 11 to 1 every day except Sunday.—Prof. Bailey is off for a brief holiday, to end with the meeting of the Institute, to which meeting everybody who is anybody, and who is not too cranky or too decrepit, is also supposed to be going—*pro bono publico*.—Dr. Nathan Starr has located at Kansas, Ill.; Dr. K. J. Severance, '89, at Vergennes, Vt., and Dr. F. W. Pease, at Sioux Falls, Dak.—Drs. G. P. & A. S. Bennett, have removed from Sioux Falls to Nevada, Mo.—Dr. M. O. Terry, of Utica, N. Y., has sailed for Europe, with our best wishes.—Prof. Shears will present the Report on Surgery at the next meeting of the Clinical Society.—Prof. Dunn is working like a beaver just now in his old orbit, but will soon settle here permanently for the practice of his specialty, the diseases of the throat and nose.—Dr. Julia M. Orr was chosen second vice-president of the Illinois State Homœopathic Medical Association.—*On dit* that our clever friend Helmuth and his "gude wife," have also gone to Europe for the summer.—The Wisconsin Central Railway will sell excursion tickets from Chicago and Milwaukee and other points on their road to the meeting of the Institute, June 24–28, for one fare and one-third.

# THE CLINIQUE.

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VOL. X.]

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[No. 7.]

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## Original Lectures.

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### *ALL DISEASES ARE DUE TO SOME LESION OF THE NERVOUS SYSTEM.*

A PAPER READ BEFORE THE ILLINOIS STATE HOMŒOPATHIC MEDICAL ASSOCIATION, BY C. E. LANING, M. D., PROFESSOR OF CLINICAL MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

A nebulous idea of the nerve centres acted upon by a remedy, and consequently of the tissues and organs affected has led physicians to assert that a given remedy *may* be indicated in any possible derangement of the organism. This is most certainly fallacious, and has resulted in much harm. It has filled our books with remedies erroneously considered valuable in certain diseases or stages of a given disease, and it has crowded the pages of our literature with alleged cures by means of remedies that have had no relation whatever to the case.

A careful study of the nature and location of the lesions giving rise to disease, together with a more definite knowledge of the sphere of action of remedies, is the cure for this evil. When I speak of the lesions which give rise to disease, I do not mean simply the gross, easily apparent ones. For it is impossible with a knowledge of these alone, to explain or elucidate the symptoms in any given case.

The pathology of cancer is studied, and when the char-



acter of the fibres and cells, which enter into its formation has been determined, it is considered to be a species of abnormal tissue development in which a certain more or less definite arrangement of cells, fibres and blood-vessels are found.

The pathologist investigates pneumonia, and tells us that the pulmonary vessels, air cells, etc., are affected in a certain manner, and hence the symptoms of the disease. And what is true of the two diseases mentioned, is equally true of all.

To stop here is as if Newton had rested when he made certain that the apple always fell down or towards the earth, and never away from it; satisfied with the fact without any explanation as to its cause.

To say that the symptoms of pneumonia are due to the changes which take place in the pulmonary tissue, is but to account for those symptoms which arise as a direct result of the great *underlying objective symptoms*, the *congestion*, *exudation* and *hepatization*. Let us but understand the reason for their presence and such symptoms as cough, expectoration, dullness on percussion and increased frequency of respiration, will be relegated to the secondary position which they deserve.

To use a homely illustration, the dust never flies except when the wind blows, or in short, until that more subtle solid, the air, has been put in motion by some force or agent which directly could not move a particle of dust. The ball is hurled from the cannon by the explosion of the powder, but this could not have occurred had it not been for the slight blow which forced the spark from the percussion cap. No force, be its tendency in a physiological or pathological direction, can affect any organ or tissue of the body until it has first made an impression upon that most wonderful structure in the universe, the nervous system. The only exception to this must be found in agents such as chemical or mechanical forces, which destroy the tissues of the body in the same manner that they would any inert substance, vital action playing no part.

Thus with disease it is the slight blow, or friction, which makes the nervous system throw out the spark which causes the great physical explosion. We cannot arrest the explosion nor prevent its results by stopping up the cannon's mouth, for if the ball is restrained from making its exit in that way, the gun will probably burst and do more harm than had it been allowed to discharge itself in a natural manner. Put out the match, dampen the fuse, and all danger is averted.

This leads me to the assertion that "*all diseases are due to lesions of the nervous system.*" I am well aware that many will dispute this and will hold that there are numerous *exceptions* to the rule, even if they admit it to be the rule.

It may be asked, how can such a theory explain the presence of the so-called blood diseases, cancer, tuberculosis, scrofulosis and syphilis? Cancer, or tuberculosis, are not considered to be nervous diseases, and yet in the strict sense of the term they are. They are not blood diseases; indeed, there is no such thing as a blood or humoral disease *per se*. The blood as a tissue may become diseased, it is true, but its condition does not represent the *fons et origo* of the disease. Some years ago a French savant claimed to be able to diagnosticate cancer simply by making a microscopical examination of the blood. He apparently did so in many instances, but at length some blood from a tuberculous case was brought to him, which he at once pronounced to be from a cancerous patient. The fact is, the blood, in many diseases, has the same or nearly the same appearance under the microscope; *i. e.*, it shows evidence of degeneration. Even if the blood of a cancerous patient underwent such changes as to make it characteristic of this disease, it would not afford the slightest evidence that the malady had its origin in that fluid. The blood is a tissue just as much as a bone, muscle or cartilage; it is built up from the nutriment taken into the body, just as certainly as are these other tissues, and all of them are constructed under the orders of the nervous system. If a bone or muscle develops abnormally, mechanical influences

barred; it is due either to the fact that the blood supplied it is imperfect, or that the trophic or vaso-motor nerves for that area are involved. If the latter be true, its nervous origin is at once seen; if the blood be at fault, then the blood-making organs are culpable. These are under the control of the nervous system, and so long as proper food is supplied the organism, they will be built up upon a physiological type, provided the nervous system be in perfect condition, and if proper nourishment is not supplied, the nerve centres will be the *first* to sound the note of alarm.

If we study the nature of cancer, it will be seen, I think, that the theory of its being a blood disease must fail. It is generally considered to be hereditary, and certainly the *tendency* is transmitted from parent to child. What is this tendency? In what part of the organism does it reside? If the blood of the fœtus came directly from the mother, and was full of the cancerous contamination, within a comparatively short time after birth, or at least after weaning, the child's blood would be entirely reformed from the food introduced into its body. If this food be of the proper quality and quantity, and the nervous system be in a normal condition, new, perfect and pure blood will soon replace the old, imperfect, diseased corpuscles which have been in the system since birth. It may be claimed that if diseased blood coursed through the vascular system at birth, none of the structures which depend upon this tissue for their nourishment could have been built up upon a physiological basis, and hence perfect blood can never be generated, since one of the necessary conditions, a normal nervous system, must be absent. While this view of the case would make it appear as if the blood was certainly the cause of cancer, we must look still further before deciding. It certainly must be, and is conceded, that a cancer represents simply a modified tissue growth. No matter what, where or how the original poison or shock which gave rise ultimately to a cancer was introduced into the organism, the nervous system was first to feel it, first to be

deranged, all other manifestations of disease being consequent and secondary.

It is scarcely reasonable, and in the light of our present knowledge of the facts untenable, to presume that, during thirty or forty years of the life of a person, the blood has been carrying within its current the germs from which cancer will at last develop. Even if this be true, why should these germs slumber for so many years, and why, in the end, attack some special structure? Why should not the entire organism be involved in the cancerous degeneration? Because, even if it be admitted that such germs exist, no portion of the economy can be attacked until the nerve centres controlling it have lost more or less of their normal power to sustain and build up physiologically the tissues of which it is composed.

Tuberculosis, scrofulosis, and diseases of a kindred nature, are certainly to be explained in the same way. The very fact of their lying dormant in the system for years, and suddenly or gradually developing in all their malignancy, is strong evidence of their nervous origin. There is no portion of the organism except the nervous system capable of retaining and storing up impressions or tendencies. The nerve cells of the brain, whose function it is to receive and register impressions made by sights, sounds, odors, etc., retain these indefinitely if not always, and they may be, and are frequently, recalled after being apparently forgotten for years. And a singular fact in connection with this is, that many times things seemingly entirely irrelevant to an idea or impression made years ago, suddenly cause it to flash before the mind as vividly as at the moment it was first received into the brain. I am fully convinced that it is justifiable analogical reasoning to infer that, just as the brain receives and retains and brings to life again, so to speak, impressions made upon it, so do other portions of the nervous system, at given times and under given conditions, bring into life and activity impressions which may have lain dormant from birth to middle life or past.

There is every reason to believe that all of the so-called

taints reside in the nervous system. They may remain unobserved for years, and may never develop to a sufficient extent to make their presence known, just as some impressions which have been made upon the brain never are recalled to life again, because the necessary stimulus is not furnished. That this is true I think there are many facts to prove. It cannot be doubted that there are many persons who have slumbering in them the demon consumption (tuberculosis), and that all that is required to rouse it to fatal activity are certain conditions and surroundings; yet, if they are never supplied, the latent fires simply smoulder during the patient's lifetime, to perhaps flash up fiercely in some of their progeny.

Some physicians, and men whose observations should carry weight, claim that in cases where a parent has had some well-defined taint or disease tendency, that medicine, often that which has been the most indicated for the parent, if given the infant soon after birth, and occasionally repeated, will effectually stamp out the inherited tendency. Whether this is a fact or not I cannot say, but it appears reasonable and philosophical.

That all portions of the economy are under the control of the nervous system is so nearly, if not quite, capable of demonstration as to allow of it being used as a working fact in solving problems connected with the physiology and pathology of the organism. Every cell, after having attained its full and perfect development, should normally be replaced by another having the same qualities in every respect. So long as this continues to be the case, every tissue and organ in the body will be constructed upon a physiological basis.

*If any of the trophic centres controlling the nutrition of a given tissue be thrown out of a physiological balance, the cells constructed under their influence will show a modified type. And this will be equally true, whether their derangement be caused by an acute lesion, or some slumbering, latent impression.*

This proposition if true, has a widespread meaning.

Let the trophic cells of one or more of the blood-making organs be deranged, and as a *consequence* other nerve centers will become involved, the first to be affected being of course those which are the most susceptible to the changes which have occurred in the blood. Then, as a still further sequence, the cells of the tissues presided over by this second group, begin slowly or rapidly as the case may be, to vary in form or number, or both, from that which is typical of normal cells. It will readily be seen that according to the location and function of the last group of cells invaded, certain reflex symptoms will make their appearance, to which we apply the name of disease. Strictly speaking, all changes except those taking place in the first trophic cells mentioned, are reflex. In them reside the idiopathic lesion, and to them should be directed the curative agent, no matter in what form prescribed nor by what route it be made to reach them. When speaking of the trophic cells controlling the blood-making organs, those influencing the entire chylipoietic viscera must be included, since the stomach and intestines are as much blood-making organs as any others. The moment the food enters a normal stomach the change begins which is to end in its being transformed into blood.

Cancers, tubercles and tumors of all kinds, have their origin in the trophic nerve cells, for all of these simply represent modified growth, impaired nutrition. That the organism is capable of giving rise to such growths, may be readily believed when we consider that through the action of the nervous system the molecules entering into the formation of the simplest foods may be so rearranged in the body as to develop substances not only inimical to the system in which they are formed, but also to others into which they are introduced artificially. Chemistry teaches us that from various arrangements of the atoms of a few fundamental substances all matter is formed. A striking example of the great change which may be made in a tissue by simply the addition or withdrawal of a single molecule, is shown by the fact that the only difference in the chemical compo-

sition of the white of an egg, so harmless and nutritious, and the deadly venom of the cobra de capello is that the latter contains one atom more of nitrogen.

At this point it may be well to glance at the germ theory of disease which by many will be looked upon as refuting the theory enunciated in this paper. The germ origin of disease is by no means proven to be a fact, and even though admitted in some cases, it cannot account for many of the diseases that the physician is called upon to treat. If, for the sake of argument, we admit that cholera, small-pox, yellow fever and typhoid fever, diphtheria, etc., are caused by germs, there is no evidence that they produce their effects in a manner differing materially from that in which drugs produce theirs. Both must first affect the nervous system before there is any evidence of disease.

If it be claimed that the germs of these diseases attack directly the blood and later the nervous system, then why is it that all who are equally exposed to their influence do not succumb to them?

There are no grounds for asserting or supposing that a *perfectly healthy* blood-disc or corpuscle, in its rounds through the vascular channels, has more power to resist germs or other disease-producing agents in one person than another. Therefore, a given number of germs of a like virulency, introduced into the organisms of two individuals, should have a like effect, yet they do not, and why?

Because in one case the nervous system, or at least the portion which is specially susceptible to the particular germ introduced, is capable of resisting its influence, and, further, because the cells governing the blood-making organs keep them in such perfect condition that either new blood is formed in reply to the demands of the nerve centres, or the diseased corpuscles are repaired, rejuvenated, with sufficient rapidity, as they pass through these organs, to prevent sufficient unbalancing of the economy to give rise to any disease. Certainly, no matter from which standpoint we start, the nervous system is the all-important structure in causing or preventing disease.

(TO BE CONTINUED.)

## Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

JUNE MEETING, 1889.

The regular monthly meeting of the Clinical Society was held at the Grand Pacific Hotel Saturday evening, June 22. Thirty-two members and visitors were in attendance. Among the visitors were Drs. S. H. Talcott, of Middletown, N. Y., H. M. Paine, of Albany, N. Y., and Dr. Asa S. Couch, of Fredonia, N. Y. The report of the evening was presented by THE BUREAU OF SURGERY, DR. G. F. SHEARS, CHAIRMAN. This report included two brief papers by Dr. Shears, which, in his absence, were read by Dr. Hoey, House Surgeon to the hospital.

I. EXTIRPATION OF THE RECTUM FOR CANCER.—The frequency of cancerous disease of the rectum, the distressed condition of the patient, the rapidly fatal character of the disease and the still unsettled technique of the operation, is the excuse I have for bringing this subject before this society. The subject is an interesting one to the surgeon, moreover, because except in a very limited degree he has not been able to apply in treatment that careful antisepsis which has made such a radical revolution in other branches of surgery.

The following is a typical case of this disease, and is given for the purpose of illustrating its history and emphasizing a few points in treatment :

*Case.* Mr. C., aged 43 years. Four years ago had typhoid fever. The disease was unaccompanied by hæmorrhage or diarrhœa ; indeed, during the whole time the bowels were obstinately constipated, and movements were secured only by enemas. Following this attack of fever the bowels were almost continually constipated and the passages frequently streaked with blood. About six months ago blood and pus began to accompany every passage, and



has continued ever since. The pain has been unremitting and during defecation almost unbearable. Emaciation has progressed rapidly, and the general strength of the patient has been so much impaired that the least exertion is a trial. The parts were so excessively sensitive that an anæsthetic was demanded before an examination could be made. Introducing the finger the whole surface of the bowel was found to be covered with a hard nodular, yet fragile mass. The calibre of the gut was so diminished that the finger was with difficulty passed through it. The speculum could not enter, but by means of a retractor and the finger the mass could be seen to be rough, irregular, and covered with an offensive bloody pus. The growth extended nearly four inches up the rectum. Extirpation of the rectum was determined upon.

The patient was put to bed for four days, and kept upon a milk diet; the bowels being moved daily by a light laxative. The night previous to the operation the bowels were thoroughly moved by a cathartic, and then washed out. Two hours before the operation the bowels were again washed out. The usual antiseptic precautions were taken as to shaving and cleansing. The operation was made as follows:

The patient being placed in the lithotomy position and a sound introduced into the bladder, the finger was passed into the rectum until it reached the point of the coccyx. Upon the finger as a guide a bistoury was passed until the point rested upon the coccyx. The tissues were then cut through so as to lay the rectum open as far back as possible. A crescentic incision was then made around the anus from one margin of the posterior incision to the other and just inside the mucous membrane. This incision was made deep enough to open up the ischio rectal fossa. By means of the finger and the knife the rectum was separated from the surrounding tissue until the levator ani was reached. This was divided by the scissors and the dissection continued until a point was reached above the cancerous mass. The bowel was pulled down, carefully examined and all hæmorrhage being controlled, a stitch was placed through the healthy bowel and integument in order to hold it in place. Four inches of the bowel protruded. This was removed by means of the scissors, the hæmorrhage from the stump controlled and the cavity dusted with iodoform. Drainage tubes were placed anteriorly and posteriorly, and the stump carefully stitched to the integument.

A long tube was introduced into the bowel to aid in the escape of flatus and a pad of iodoform gauze applied.

The patient made a good recovery. Within two weeks from the time of the operation he had gained several pounds and was able to go home within four weeks. A week ago, about nine months from the time of the operation, I addressed him a letter. In reply he said he was about, tending to business, but was troubled with incontinence of fæces.

The relation of the constipation to the cancerous disease is to me a question of interest. Did it produce the disease or was it caused by the disease?

What are the results of this operation as to cure, to mortality, as to benefits derived is a question frequently asked. It cannot be answered by the consideration of a single case, but must depend upon the facts deduced from an examination of a large number of cases.

Complete cures, those in which after many years there has been no return of the disease, are not numerous, and statistics are difficult to obtain. Of 60 patients operated upon in the Göttingen clinic 10 per cent were free from the disease over three years, and 18 per cent over two years. Allingham records several cases in which many years had elapsed and no return of the disease, one case the time being over seven years. This record of cures is only a partial indication of success to be obtained, for of the many cases lost sight of it is quite probable that many are to be included in the favorable list. When it is remembered that it is the rule for a cancerous disease to return before the expiration of the second year, if it returns at all, the statistics given above are not unfavorable.

The mortality of the operation has been, until recently, of the most serious character. Of 100 cases collected by Butlin from the published cases of Billroth, Fischer, Voigt, Allingham, Cripps and others the mortality was 35 per cent. Dr. Hildebrand, from the Göttingen clinic reports 57 cases with a mortality of 35 per cent during the first six years, and 14.9 per cent during the six years just passed. At this point it may not be inappropriate to consider for a moment

the treatment of the stump and wound, for it is believed by many to have the most important bearing upon the question of the mortality of the operation.

Two methods are in vogue: (1.) The simple removal of the mass, leaving the divided ends in place. (2.) The deep suturing of the stump to the external wound, with proper drainage. The first of these methods is strongly advocated by Butlin, who says stitching is not desirable, (1) because the stitches give way in the course of a few days, the mucous membrane retracts, and no advantage is gained. (2.) So long as the stitches hold, there is danger of *fæces* collecting behind the mucous membrane, and burrowing up the bowel, from which the most diastrous consequences ensue.

In commenting upon the causes of death in the fatal cases reported from the Vienna clinic, he says that death took place, almost invariably, from retroperitoneal abscess, exactly the condition we should expect to find if the bowel were united to the skin, and an opportunity offered for the *fæces* and discharges to be retained. Allingham, whose success—a mortality of five out of thirty-six cases operated upon—is certainly satisfactory, is not in the habit of uniting the divided bowel; indeed, he says he has met only two cases in which it was a success. In other instances the sutures were torn out as a result of traction, or had to be removed to clear away pus. The second method, that of drawing down the stump, and suturing to the integument, is the one more commonly practiced by continental surgeons, and is the plan followed in the Göttingen clinic, whose admirable reports I have several times quoted. It is the plan I have invariably followed, and with good results. While undoubtedly adding to the possibility of septic complication, it possesses so many advantages in the way of rapid cure and relief from stenosis that its acceptance is fully warranted, especially when the patient can have the care of a skilled surgeon; for it is a fact, entirely demonstrable by recent statistics, that thorough drainage and more perfect antisepsis can overcome the greater risk of the stitching

process. In those cases in which the tension is extreme, the possibility of necrosis of the stump is so great that nothing is to be gained, the stitching process can be dispensed with.

As a rule only a partial return of the function of the bowel can be promised. Of thirty-six cases reported by Cripps, only seven were able to control the bowel, and of these six were unable to do so if the secretions were fluid. Similar results are reported by Allingham, Hildebrand, Bergman, Kœnig, and, indeed, all operators of note. In case of partial excision, or in cases in which the sphincters remain intact, much more favorable results may be obtained.

In this brief paper no mention has been made of the extensive operations practiced by Alexander and Kraske, in which the coccyx and portions of the sacrum are removed, believing, as I do, that in such cases the prospect of radical cure is so small that inguinal colotomy offers much more to the patient, both as regards safety and comfort.

II. TUBERCULAR CYSTITIS, PERINEAL CYSTOTOMY.—The infinite variety of lesions which tuberculosis may produce, and the localities which may be affected, are probably well known to all of us, and yet there are certain organs which are less frequently attacked than others, and it may not be uninteresting to record some of these rarer cases, among which may be classed tuberculosis of the bladder. The disease, so far as I know, is not primary in the bladder, the course of infection being from the kidney to the bladder, or from the testicle to the bladder.

*Case:* The following case came recently under my care: Six months ago E. H., aged 25, noticed that he was obliged to urinate more frequently than usual, and that urination was accompanied by some uneasiness. He gave the subject little attention at first, but as it became more and more troublesome, he consulted a physician. Nothing was gained by treatment, and he came to Chicago for a more thorough examination. At this time he was obliged to urinate every half hour, day and night. There was constant pain in the end of the penis. The urine flowed, and stopped, and

again flowed after movement of position. Careful examination by the sound detected no stone, but indicated great sensitiveness of the bladder wall. The urine contained some pus. The general appearance of the patient was not bad, appetite fair, no cough. Two years before he had had the right testicle removed, it being diseased and painful.

The patient was placed on a supporting diet, the bladder washed out daily with hydrastia, and appropriate remedies presented. For a few weeks the patient improved, but this did not last long, and was followed by chills, fever, night sweats, but, worst of all, constant excruciating pain in the bladder, and constant desire to urinate. The pain was so excessive that he could not eat or sleep. Prof. Arnulphy examined him, and found tubercular localizations in the liver, kidney and right lung. It was determined to make the operation of cystotomy, to relieve pain and explore the bladder. This was done by me on April 18th, making a perineal opening. Upon entering the finger into the bladder, its cavity was found to be almost entirely filled with a spongy, friable mass. A permanent drainage tube was introduced.

The operation gave immediate relief, and from this time until his death he was entirely comfortable. Indeed, for several weeks he seemed to improve in strength. He lived five weeks, and during this time could not say enough of the great relief he had received from the operation.

DISCUSSION.—DR. C. S. MACK had seen only one case of cancer of the rectum, which was peculiar in that the patient was only about twenty-two years old. He had already been operated upon a year previously and the disease had returned. I do not know what became of the case, as I lost track of him after four months. I would like to ask as to the choice between extirpation of the rectum and colotomy.

DR. H. P. SKILES. Is there not the same relation between injury of the rectum and cancer as in a case of injury of the cervix uteri and the development of cancer? We all know the frequency with which cancer follows a laceration of the cervix. May not the surgeon be responsible for a cancer developing in the rectum?

DR. T. S. HOYNE. In response to a request from the chair for the medical treatment, Dr. Hoyne said: I believe

that the man mentioned in the first case would have lived longer from the administration of homœopathic remedies than from the operation. The urinary symptoms reminded me strongly of *Conium*. I have frequently covered these symptoms with that drug. I do not know what the effect of the medicine would be when the trouble was due to tuberculosis. In cancer of the rectum *arsenicum* is, by far, the best remedy we have. A large percentage of all the cures reported during the last twenty-five years were accomplished with arsenic. *Silicea* ranks next in utility. The antiseptic treatment amounts to nothing. The English surgeons have about come to this conclusion. Experiments are now being made in the same hospital. In one ward strict antiseptic cautions are observed, while in an adjoining ward only ordinary cleanliness will be used, and the final results are as good under one system as the other.

DR. ROGERS. I never saw but one case of cancer of the rectum. It occurred in a man of thirty. He died six months after the diagnosis was established.

DR. R. LUDLAM. A paper recently appeared in the London *Lancet* arguing the importance of studying rare cases of disease, as they give the key to the more common ailments, and that each case has its bearing on cases in other lines. Tuberculosis and cancer have been considered by most authors as very different, by others as closely related. The French have done the most in the surgery of tuberculosis.

In the last case reported nothing was said as to heredity, and no post-mortem was made to verify the diagnosis. It is unfortunate that Dr. Shears is not present to explain and defend his paper. Enough detail is not given to distinguish between the different papillary and cancerous growths that may occur within the bladder. It is almost impossible by means of the finger introduced within the cavity of the abdomen to differentiate a cancerous from a tuberculous deposit, and the same is true when they occur on a mucous surface.

Tuberculosis of the bladder does occur, but I am not

certain that it is ever cured. Nothing is so fallacious as statistics. In the first case they do not really prove anything. I suspect that most of the reported cases of cancer of the rectum that have been apparently cured were in reality tuberculosis, which is far more common than tuberculosis of the bladder. In a case that I reported in the *Clinique* for November, 1882 (Vol. III, page 404), I removed four inches of the rectum from a patient of Dr. E. Z. Cole, of Michigan City, Ind. The disease had extended three and a half inches. The wound was closed with ten silver sutures. The woman made a good recovery, but died a few months later of a rapid pulmonary phthisis. I have no doubt that the rectal disease was tubercular.

DR. L. D. ROGERS. A physician of New York has announced a new diagnostic sign of tuberculosis based on the morphology of the blood. He claims to have found that in a case of tuberculosis the red corpuscles will be massed together, while, if tuberculosis is not present, the corpuscles will be evenly distributed over the field of the microscope.

DR. G. A. HALL. Of all the organs the rectum is, by some authors, thought to be the one most frequently involved in cancer. I have seen cases in which the calibre of the bowel was reduced to the size of a lead-pencil without the patient being aware of any trouble.

While in New York, recently, I found a case in company with Prof. Helmuth which was said to be a prostatic bladder trouble. We could obtain no history of there having been any rectal difficulty. On entering the house we observed that the patient presented the facial signs of acute suffering. In response to the question he indignantly denied having any rectal trouble. "Why, doctor, it is the only perfect working part of my anatomy." On attempting to introduce the finger into the rectum it was found so sensitive that we were obliged to give him chloroform; and on reaching the upper quadrant, an Ives speculum being used, a profuse hemorrhage occurred. It was just what I expected to find from the appearance of the patient. There was an epithelial formation on the upper portion of the

rectum and lower end of the sigmoid flexure with exuberant granulations that bled at the slightest touch.

If the rectal pouch is involved for a greater distance than four inches in the male, or three and one-half inches in the female, the operation is hazardous. If the sigmoid flexure is involved, the only treatment is to keep the passage open. Colotomy is the only alternative. I would only perform this latter operation when it was necessary to prolong life, as in the case of a business man who desired to settle his affairs, or some similar case. The condition that is left is the most disgusting and uncomfortable imaginable. If I were called upon to make this operation, I should first open the common carotid, and then perform the colotomy.

Thirteen years ago I removed the lower part of the rectum from a woman. She has since had several children, and a number of miscarriages. Until recently there has been no trouble, aside from a diarrhœa. Now I am obliged to use bougies, the stricture being about two-thirds of an inch in diameter. I would operate on her now, but for metric influences. During the present bad weather all of my operations are doing badly. The finger can be introduced half way, but above that the tissues are all involved. I believe we have cancer of the sigmoid flexure more often than of the lower gut.

*Case:* A case was recently sent to me by Dr. McClelland, of Pittsburg, as he was unable to operate on account of an injury to his hand. A former physician had used bougies, but could not introduce them more than four inches. On local examination I found the rectum filled with the convoluted gut. The uterus and ovaries were prolapsed on top. I replaced the uterus with Dr. Ludlam's elevator. The trouble here was due to inflammation and ulceration caused by the punching with the bougies. I do not know whether there was trouble at the sigmoid flexure or not. I stretched the sphincter, and, after replacing the uterus, readily introduced a tampon saturated with boro-glyceride about ten inches by means of the long-curved forceps. This was at 2 p. m. At 8 p. m. she attempted to turn in bed, when a sharp pain occurred at the upper por-



tion of the sigmoid flexure. This was the most severe pain that she had ever experienced. Dr. Halbert gave her morphine, and when I found her, fifteen minutes later, she was in such pain that I gave chloroform. On examination I found a "lump" in the side that I had not observed before. In the morning she was better. I decided that there was occlusion of the bowel. That night she was seized with a severe pain in the region of the gall-bladder, and died the following morning.

On making a post-mortem, I found a cancerous degeneration of the colon and of the lower end of the cæcum. The middle lobe of the liver was degenerated. The gall-bladder was immensely distended, the common duct being occluded. The appendix vermiformis was as hard and stiff as a pipe-stem. It was then learned that she had been subject to severe pains in the gall-bladder.

An operation for cancer of the rectum is not practicable if the trouble is over four inches distant, or if the surrounding tissues are involved. If it can be removed without attacking the surrounding tissues it is one of the easiest operations. If above four inches, or if the sigmoid is involved, an operation is not possible, colotomy being the only thing, and this should not be done until after the autopsy.

VOLUNTEER PAPERS. I. THE CO-EXISTENCE OF ERUPTIVE DISEASES.—By S. J. QUIMBY, of Cheyenne.—I was highly interested in the report of cases of Dr. Poppe in the CLINIQUE of March 15, and also in that of Dr. Rile, in the May number. During the winter and spring, and sometimes early in the summer, for the last five years there has prevailed in this vicinity a disease bearing these mixed characteristics. It has been regarded by us as *rubella* the *rotheln* of the Germans. The prodromic symptoms are delirium at night, nausea, sore throat and more or less pain in the head, back and limbs. These are soon followed by a sudden rise in the temperature, the thermometer indicating from 102° to 105° in the axilla. The fever continues until the sixth or eighth day. As soon as it has become pronounced the eruption usually appears and is always recognized first upon the trunk, being especially marked upon the back. It then extends to the extremities and vanishing in the same order, disappears entirely by the sixth or eighth day. It presents the general characteristics of scarlatina.

There is, however, scattered more or less throughout the eruptive field, coarser red points, which are massed in somewhat semicircular groups, like those of measles; only more angular. When these groups predominate, the eruption closely resembles that of measles, at other points that of scarlatina. The color vanishes upon pressure but gradually returns when the same is removed. There is also sometimes interspersed throughout this eruptive surface white spots of clear skin, and occasionally numerous minute, white vesicles are to be seen, principally about the hips. Desquamation commences about the fifth day, and continues for two or three weeks. In mild cases it appears in the form of small, bran-like scales; in others the epidermis peels off in flakes.

There is nothing characteristic about the pulse. The tongue is usually moist and covered with a thick, white fur, through which extend numerous small, red points. It cleans up about the fifth day, and assumes a smooth, red appearance. In severe cases it becomes dry and brown in the center. The tonsils and pharynx are early congested, and often the entire fauces become covered with membranous patches.

There is frequent bronchial irritation manifested by a dry cough, to be followed in severe cases by a catarrhal affection of all the bronchiæ, mucous rales being audible over the lungs. In this class of cases the membranes of the nose and ears become involved. There is more or less intolerance of light, and the conjunctiva is reddened and watery. Rheumatic pains in the joints are sometimes present. Otorrhœa has been a sequel, but dropsy has not. One patient suffered the loss of an eye, and several have died. A previous attack of either scarlatina or measles has furnished no protection against this peculiar disease.

2. FRACTURE OF THE INFERIOR MAXILLARY.—BY ALFRED W. HOYT, D. D. S., CHICAGO.\*—The treatment of maxillary fractures frequently calls for the exercise of a higher degree of mechanical ability than those of other bones, because of the wide difference in their shape, but more particularly on account of variations in teeth, the number present, if any, size, shapes, arrangement etc., no two cases

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\*Lecturer on Dental Surgery in the Hahnemann Medical College and Hospital, of Chicago.

being alike. The most positive method of treatment in the majority of cases is the application of a perfectly adapted mechanism attached to the teeth, but each case has its peculiar needs and hence its proprietary appliance. It is for these reasons that dental surgery is so often called upon to assist in cases not amenable to the common modes of treatment, *i. e.*, by external splints. While dental plates and bands of various forms are much used and quite indispensable, the simple intelligent handling of pure silver wire is susceptible of a much wider field of usefulness, and in some cases is about the only effective means at hand, as illustrated by the following case which occurred in my own practice.

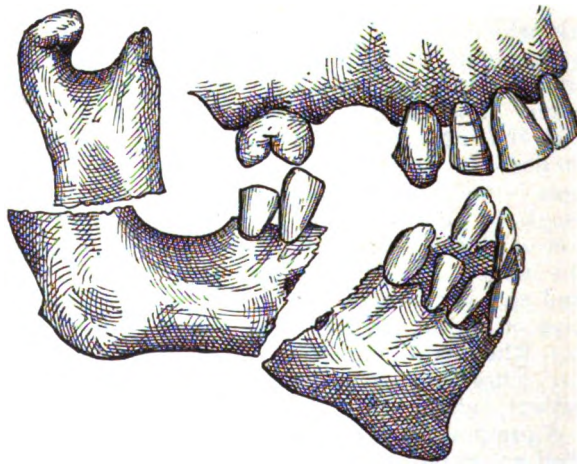


FIG. 1.

CASE.—My patient, a gentleman aged forty, had a compound fracture of the right inferior maxillary, and one which is by no means common, as a glance at the cut will show (Fig. 1). I believe it is not usual for the rami to be broken so squarely across, the majority of breaks being across the angle.

For eight days previous to my attending this patient external splints and bandages had been used with no success and his condition was deplorable and painful, to say the least. As shown in the drawing the body of the bone was pushed well back of the rami and the chin drawn

down and backward. The parts were largely swollen and there was a profuse and very offensive discharge of pus. I interlaced and twisted silver wire (about 1-32 of an inch in diameter) between and about the cuspid lateral and central incisors of both sides above and below, leaving the eight ends, each about six inches long and protruding from the mouth.

This was a very slow operation as the space was small between the upper and lower teeth, and the inter-spaces between the teeth were so bathed by the discharge that all

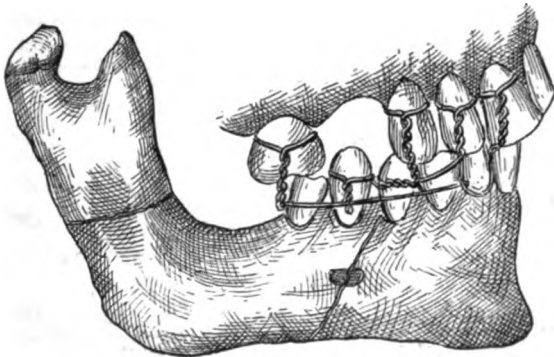


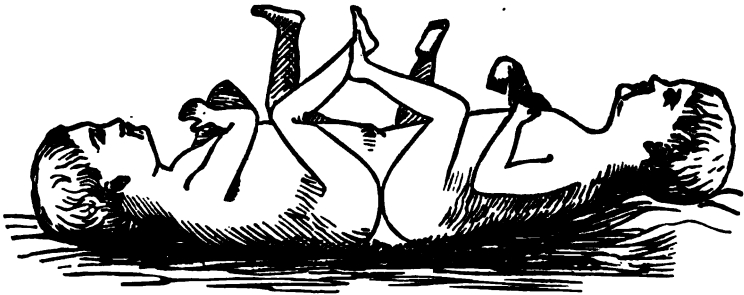
FIG. 2.

the work was done by feeling rather than by sight. After administering chloroform we were enabled by using much force to bring the teeth to antagonize normally, then the sets of wires were securely fastened together. Wires were also placed so as to draw the surfaces of the anterior fracture together (see Fig. 2), cessation of pain followed at once but the action of the parotid glands was excessive for four or five days.

I also applied a splint externally to the entire lower jaw. This I made by taking several thicknesses of window screen wire adapted as perfectly as possible, the edges bound with heavy adhesive plaster and lined throughout with a thin layer of plaster of Paris. This splint was applied while the plaster was soft, precaution being first taken to place a layer of tissue paper over the face to prevent sticking to the ten days' growth of the beard. When well bandaged this furnished a perfect and comfortable support, taking some of the strain off from the teeth.

In twenty-one days the wires were removed, a good union having taken place. A week or so later an abscess formed under the chin but this healed rapidly after opening. On complete recovery the face and arrangement of the teeth was normally symmetrical.

3. TWINS THAT ARE NOT TWINS.—BY DR. F. W. BAKER, OF KOKOMO, IND.—The accompanying cut is an exact illustration of a pair of twins. They were born here June 24th. The mother is a young woman aged 19. She weighs 100 pounds. There is no history of injury, or fright, or of aught uncommon. The only incident that can now be recalled by the parents or the friends is that, in March last, the mother stepped into a hole and sprained her ankle. She has a daughter two years old that is normal in every way. The father is a robust farmer of 24 years.



The body of the children is 23 inches long. It weighs 12 pounds. There are two distinct alimentary canals; also urinary organs. The vulva is just below the junction of the legs on either side. The anus is a little further back. The spinal columns do not meet by about a half an inch. One has to look sharply to distinguish a difference in the development of the two. Both have had proper stools and discharge of urine. They sleep at the same or different times. There was but one umbilical cord, which is shown in the cut. They are five days old now and hearty. I send you this because I think it will be of interest to readers of THE CLINIQUE.

4. "ORIFICIAL" WORK IN CHRONIC CASES.—BY DR. H. P. SKILES.—It is three years since I made a partial report on this subject to this society. Since that time I have no reason to retract anything that I then gave, although I have

been engaged in this work ever since. For the benefit of the members who were then present I wish to state that the cases then reported have remained in good health without further treatment.

It is my purpose at the present time to give "a reason for the faith that is in me," or rather the principles on which the work is based, and a few cases illustrating the same.

1. It is admitted by all that the sympathetic nervous system controls digestion, circulation, respiration and assimilation.

2. That the great sympathetic has its peripheræ in the orifices of the body—viz., the throat, the penis and the rectum in the male; the throat, the rectum, the vagina and uterus in the female.

3. A nerve being affected in its periphera, it will affect the whole nervous system of which it is a branch.

It seems also that the same principle which applies to the sympathetic inflammation of an eye (the other eye being inflamed), is applicable to orificial work. For instance, if we have a chronic endometritis and it is not cured, we will sooner or later have a proctitis. Such a case of proctitis cannot be relieved unless the endometritis is relieved.

Or, if we have a chronic proctitis, we will sooner or later have an endometritis, and we must relieve the primary inflammation before we relieve the secondary. A patient may have a chronic inflammation without being conscious that the trouble is located at the seat of the inflammation. Every physician knows that there may be a chronic endometritis without any pain in the uterus. So, also, we may have a chronic inflammation in the urethra or the larynx without any pain at the seat of the disease, or even without the patient knowing that there is any serious difficulty there. It is the privilege of the doctor to trace from the symptoms the cause of the distress of the patient, no matter how remote it may be, and unless the cause is found, it is as a rule folly to try to relieve the patient.

If we know absolutely that one or more branches of the great sympathetic are involved in a certain patient, it would

be impossible to tell the exact final result in that individual case, but we would know that there would be an abnormal repair—but what that abnormal repair would consist of—whether it would be in the formation of an ulcer, a congestion, an abscess, or a tubercle, is unknown. I cannot tell all the results of such a cause, as they are too numerous to mention. And while I do not believe that by rectifying the inflammation, or ulceration, or abnormal growths or redundancy of the parts of the orifices will cure every chronic case, it will help to make a complete and permanent relief of a great majority of chronic cases.

*Case 1.* Mrs. Y., aged 35, married, mother of two children, about 8 and 10 years of age. Was called July 17, 1887. Found that she had been confined to her room for eight weeks with what her physician called malaria. She had taken a great deal of quinine until this morning, when she refused to take any more. Pulse 100, temperature 99°. Had difficulty in getting her breath. Would very often have to rise up in bed to get her breath. Said that her physician was trying to get her ready to have an operation on the cervix. Examination revealed the cervix to be in good condition; had had a slight laceration and the os uteri was a little red. The rectum showed papillæ in great abundance. They were arranged in pairs all the way around the rectum just inside the internal sphincter, about a quarter of an inch or more in length. She had had many physicians, and had not been well for fifteen years; was unable to get at the primitive cause of these papillæ, but it has been my experience that they often come from a dysentery. It was Sunday morning, and I promised to completely relieve her the next morning, and that she should be up in three days from the time I operated. I operated on Monday, and on Thursday she left her bed. I saw her a short time ago, and she says she has had no trouble since.

*Case 2:* Mrs. A., German, over 50 years of age, from Milwaukee, was brought to my office in June, 1887, by her daughter of this city, who said that her mother had a great deal of stomach trouble, vomiting quite frequently, and had also some constipation. I told the daughter that her mother was insane, which she admitted. Said she slept very little, and at night would take the broom and endeavor to sweep from the ceiling imaginary objects, becoming at

times quite violent. On examination I found the uterus in a normal condition and atrophied, the menses having ceased normally several years previous. The rectum was partially prolapsed and everted all the time. That afternoon, assisted by two other physicians, the patient under ether, the sphincters were stretched. I removed the redundant portion of the rectum in two sections, controlling the hemorrhage by a Knott's clamp. The clamp being removed, all the little shreds and bruised tissues cut away, the patient was placed in bed. She came out nicely from the ether, and improved from day to day. The appetite returned, the sleep was thoroughly restored in a few days, but owing to the contraction of the cicatrix I was compelled to dilate the sphincter every few days for several months. The bowels moved normally, very little medicine was administered, and I am happy to state that the mania did not return after the day of operation.

*Case 3.*—Mr. H., farmer, aged 46, came from Colorado in June, 1888, for a prolapsed rectum, which he had replaced one or more times every day for seventeen years. Is unable to do but very little work. Says he often is compelled to stop his work to replace his rectum. He was anæsthetised with a good deal of difficulty, respiration being very poor, and the heart very irregular. The sphincter ani was very thoroughly stretched, although I was compelled to ask the doctor who assisted me to put his hands between mine, and help me to dilate, on account of the enormous strength of the muscles. The amount of tissue caused me to make three sections of the protruding rectum. Each one was taken separately, using the small rectal forceps, from three to six as the case demanded, drawing the part down, clamping with a Knott's clamp, and then, before the clamp was removed, I put in stitches to hold the mucous membrane in situ; then removed the clamp and tied the stitches. The patient was put in bed, and soft cloths wrung from hot water were applied to soothe the pain. The third and fourth days his temperature was from two to three degrees above the normal; but that was controlled without difficulty. The bloating was relieved by inserting into the rectum the female tube of an ordinary family syringe, letting the gas escape. The wound healed kindly, almost entirely by first intention, and the patient was ready to go home in two weeks from the day of operation. He now has no trouble with his bowels. They are regular. His appetite



is good, and he writes that he is better in every way than he has been for many years.

*Case 4.*—Mrs. P., aged 25, married, American. Has one child, 17 months old, and has not menstruated since her child was born. I was called at one o'clock, a. m. Found the patient in a mild delirium, with a high fever; one of the breasts was very hard and inflamed, which was opened the following day, discharging a quantity of pus. The fever and delirium continued for eight or nine days. I told the husband and mother that the suppurating gland was probably produced by some trouble with the uterus. For fever, gave the ordinary remedies—acon., bell., ver. vir., etc. As soon as the fever had subsided I gave chloroform, and examined the uterus. Found it retroflexed and measuring eight inches in depth. Dilated the cervix, put the uterus in a normal position, and stretched the sphincter ani. I gave *secale cornutum*, ten drop doses of the fluid extract, three times a day; also *ferrum cit. et strychnia*. The delirium continued, it taking two or three to take care of her night and day. I gave chloroform about every two weeks, so that I could dilate the cervix and replace the uterus, which assumed normal proportions at the end of about two months. The appetite returned, the bowels became regular, the mental equilibrium was restored, the menses were established, and now for two months she has been better in every particular than for years.

*Case 5.* Mrs. R., German, aged 35, one child 8 years old. Tall, thin, anemic, constipated, poor appetite, slept poorly, eyes bad, had to wear glasses for seven years, menses profuse. Examination reveals bi-laceration of cervix with endometritis, also a chronic proctitis with a tight sphincter ani. The patient being under ether I operated according to Emmet for the laceration, and stretched the sphincter ani. The patient kept her bed one week. I have dilated the rectum twice since. The bowels are regular, the menses normal. She has improved in flesh, the appetite is good. She sleeps well, and does not need eye-glasses.

*Case 6.* Mr. B., American, aged 27, married, came to me about May 10, of the present year. Temperature normal, pulse 130, difficulty in breathing, was most troubled about his eyes. By stretching the sphincter ani a very little the pulse dropped to 70 inside of five minutes. When I told patient if he would put himself under my care for a month I would help his eyes he said he had no faith, that

three oculists had refused to fit him with glasses, and that an optician had fitted him, although they pained him very much. I assured him that I could help him, and that the little I had done would help him some. A few days afterward he returned, and Dr. Crawford having called on me was shown the case. The patient confessed that his eyes were stronger than they had been for years, and that he would give me all the time I wanted as soon as he could arrange his business to suit. In company with Dr. Crawford, on the morning of the 12th of this month, I operated, removing some papillæ and pockets, and stretching the sphincter thoroughly; also completely circumcising the prepuce and passing a No. 15 English sound into the bladder. Before we operated the prepuce was quite snug, the urethra inflamed, it taking him five minutes to void his urine. Bowels constipated, sleep poor, eyeballs red and congested, burning pain in the eyeballs all the time, could recognize no one by sight unless within a foot of him. Next day eyes clear, no pain anywhere except where I operated, and to-day he can see the children play across the street from his window. Bowels are normal, appetite increased, voids urine easily, and says if he is only as well always as he is now, he will be satisfied.

When he was ten years old he had inflammation of the bowels, which lasted eight weeks. At the end of that time inflammation of the eye set in, and he had to be led to the doctor to have his eyes treated. Since that time they have bothered him continually.

5. THE TREATMENT OF THE PERINEUM DURING LABOR.—By DR. LUCY WAITE.\*—Every accoucheur decides, early in his practice, as to his method of treating the perineum, and if under his method he has a measure of success, it is a difficult matter to convince him that there is a better. The first question to decide is whether or no the perineum shall be manipulated at all. Some of our leading obstetricians have put themselves on record as opposed to all forms of manipulation, classing them under the odious title of meddling some midwifery. It seems to me that, keeping in mind the two objects to be gained—the prevention of too rapid delivery of the head, and the favoring, as far as possible, the minimum pressure on the posterior pelvic floor—skilled manipulation of the head and perineum cannot fail to aid in guiding the head safely through the narrow canal which it is obliged to pass.

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\* Read before the Ill. Hom. Med. Association.

It would be impossible in the limits of this paper to give the numerous methods practiced for the preservation of the perineum. For my own part I am a convert to the German method as practiced in the hospitals of Drs. Sparte and Braun of Vienna, and to bring this matter before you as concisely as possible for discussion, beg leave to state in brief the *modus operandi* in vogue in those hospitals. In detail it will not, of course, be applicable to private practice, but, carried out entirely by the physician, the principle is the same.

The service of the hospital, as far as the obstetrical patient is concerned, consists of the house surgeon, the head midwife, and the midwife who is in training. The normal case of confinement is under the care of the midwife in training. It is her duty to watch the progress of the case, and, on the bulging of the perineum, the patient is drawn to the edge of the bed, and turned upon her left side. The limbs have been previously wrapped in sheets. An assistant sits on the edge of the bed and supports the right limb, so as to raise it up and off of the arm of the operator. The operator takes her position at the back of the patient, passing the left hand over the right limb and between the thighs, and presses back the oncoming head with the fingers of the left hand. The ball of the right hand covers the anus, the thumb being placed on one side of the perineum, and the fingers on the other. The central perineum is thus left in sight between the thumb and first finger, and is at no time subjected to pressure. In this position the head is under perfect control, lying between the two hands of the operator. With the right foot raised upon a stool or round of a chair, and the elbow of the right arm resting against the right knee, the operator is in a position to use to the best advantage all the strength he possesses. Given this position of both patient and operator, the delivery of the head without laceration of the perineum, in any case which can reasonably be called normal, becomes a matter of strength, patience and judgment.

The head is really delivered between the pains. During pain the head is crowded back by the fingers into the vagina, allowed to advance only enough to put the perineum slightly more on the stretch than after the last pain, and between the pains the head is pushed by the ball of the right hand very gently upward and forward, away from the pelvic floor, and under the pubic arch. The head is practically rolled out between the two hands.

The perineum is thus stretched, line by line, and the head must be large and the perineum indeed tough which cannot be managed in this way, if sufficient time is taken.

The rules of the hospital require the attending midwife, if she has any suspicions that she is not going to be able to manage the case successfully, to summon the head midwife. The one in this position during my stay in the hospital had held it for thirty years, and was a most accomplished accoucheur. I have seen her deliver a large head when the perineum was stretched as thin as tissue paper, and the features of the child plainly visible through it. In such hands the manipulations become a work of art. As the thin membrane passes over the nose and chin, the assistants unconsciously catch their breath, and cannot believe that the perineum is saved. Scylla has been passed, only to meet Charybdis in the next moment. The delivery of the shoulders must be managed with the same skill, or all has been in vain. If the shoulders do not of themselves turn into the antero-posterior axis of the canal, they are quickly turned, and the shoulder, pressing upon the perineum, delivered first, the other follows, and the second stage of labor is completed.

There are, of course, cases which even the skilled fingers of the over-madam, as she is called, cannot successfully manipulate, and it becomes her duty, when she sees a threatened rupture, to summon the house surgeon, who immediately performs episiotomy. This is done by one cut made to the side from within out, from one-half to an inch, according to the judgment of the operator. The immediate operation is made, in all cases, and the patient leaves the hospital with a sound perineum. No anæsthetics are used in normal cases, and no lubricants of any kind. In fact, it would be impossible to manipulate the perineum in this way if the parts were more slippery than they must be under the natural lubricating fluids secreted at this time. A large reduction in the per cent of lacerations is claimed for this method; twelve per cent in all cases, as opposed to fifteen to forty per cent under other methods.

When the forceps are used in head presentations, the patient is delivered on the back, the same general method being used, the forceps taking the place of the left hand.

## Hospital Notes.

### THE CLINIC ON GYNECOLOGICAL SURGERY.

#### SERVICE OF PROF. LUDLAM.

EXTIRPATION OF THE WOMB FOR HYSTERO-EPILEPSY AND CHRONIC RETROFLEXION, WITH RELAPSING PERITONITIS OF SEVENTEEN YEARS' DURATION. RECOVERY.—*Case 17,800.*—On Wednesday, June 12, Prof. Ludlam made another vaginal hysterectomy at the hospital by Péan's method without ligatures. In his subsequent remarks the class was told that the patient was sent to the hospital in October, 1886, since which time she has been under almost constant observation and treatment. She is now 40, the mother of one child twenty-one years old, and has been an invalid for seventeen years. She has for many years had an inveterate retro-displacement, and double ovaritis, with epileptiform attacks, which until a year ago were very frequent and severe, sometimes recurring as often as ten times in the twenty-four hours. These fits were of the classic description detailed by Charcot, and the patient was the subject of a clinical lecture in which during one of them the effect of pressure upon the ovarian zone was demonstrated to the class. (The full particulars of this case as noted by Dr. F. C. Stewart, the House Physician, may be found in the *Clinique*; Vol. VII, page 446.)

Despite all that could be done for her with remedies and local means she grew worse and suffered so severely that on May 29, 1888, I made an explorative laparotomy with the intention, if possible, of removing one or both the ovaries and tubes. This indication seemed the more imperative because the convulsive attacks had assumed a distinctively menstrual type, and because the ovarian suffering had become intolerable. But, although in similar cases I have often encountered the worst kind of peritoneal adhesions, and once before had occasion to relinquish my purpose, these organized exudations were so universal and so firm and unyielding that I did not think it prudent to tear the ovaries out. I therefore liberated the parts so far as possible, after the manner of Dr. Lusk, and closed the wound in the usual way. The patient made a slow but uneventful recovery. For some months, under the care of my son, her

health was decidedly improved, and the convulsions did not recur, but of late she has had frequent relapses of pelvic peritonitis, with vesical suffering, vomiting, constipation, tardy and very painful menstruation and a few slight spasms.

She begged me importunately to "do something" more for her relief and I finally consented to operate again; but what to do was the question. Alexander's operation, by shortening the round ligaments and pulling the uterus into position would not answer, for the adhesions and the anchorage of the ovaries rendered it impossible. To attempt to right the womb and stitch it to the abdominal parietes, hysterorrhaphy, was equally impracticable; and supra-vaginal hysterectomy, under the circumstances, which since I had made the exploratory incision were so well known to me, meant murder, neither more nor less. The only expedient left was that of vaginal hysterectomy, and in making this operation the ovaries would probably have to be left behind.

The entire uterus was therefore removed, its adhesive bands clamped and severed, and the hæmorrhage controlled by the forceps, which were allowed to remain for forty hours. There was no shock, or loss of blood, and with excellent nursing and the good care of Dr. Hanna, the house physician, she has convalesced steadily and surely. On the sixth day, however, it being the time for the monthly return, she became excited and nervous over the noise in an adjoining room, and between 12 m. and 7 p. m., her temperature suddenly mounted from  $100\frac{1}{8}^{\circ}$  to  $106\frac{1}{8}^{\circ}$ . In another hour it was  $104^{\circ}$ , in two hours  $105\frac{3}{4}^{\circ}$ , and in three hours,  $102\frac{3}{4}^{\circ}$ . The next morning at 1:30, it was  $109^{\circ}$ , and at 4:30 a. m.,  $99\frac{3}{4}^{\circ}$ . There was no special pain, no delirium, no convulsion, no chill and no crisis of any kind, the vaginal discharge being free all the while, the douche being repeated every two hours while the temperature was high. On the eighth day at 7 p. m., the thermometer in the mouth recorded  $106^{\circ}$ , and at 11 p. m. it was  $114^{\circ}$ , as indicated by two different thermometers, and very carefully noted; but one hour later it had dropped five degrees! This extraordinary record is chargeable to the highly neurotic condition of the patient, for it was not accompanied by serious symptoms of any kind. The pulse has not been above 100.

July 10. Four weeks have elapsed and the patient is sitting up in bed, eats well, and looks better than she has done in months, or even years. Her temperature is nearly normal, and she is almost well again.

## Miscellaneous Items.

The "Old Hahnemann" graduates came up grandly at the meeting of the American Institute; Dr. J. E. Sawyer, '82, of St. Paul, and President of the Minnesota State Hom. Society, welcomed the guests in a felicitous speech; a goodly share of the reception committee from the "twin cities" were of our boys, and made their old teachers very welcome; of the 116 new members elected to the Institute, *fifty-five* were graduates of this school in Chicago; and last, but not least, a loyal old alumnus of the same institution, Dr. C. J. Higbie, was made its Vice President for the ensuing year.—Next year we meet in Waukesha or Oconomowoc.—After the sessions were over, a choice group of twenty-one made a ten days' excursion a thousand miles west to the Yellowstone National Park, the party consisting of Drs. H. A. Houghton, of Boston; H. M. Hunter, of Lowell, Mass.; A. B. Norton and wife, F. E. Doughty and Geo. M. Dillow, of New York; C. W. Butler and wife, of Montclair, N. J.; J. G. Streets and wife, of Bridgeton, N. J.; E. M. Howard and wife, of Camden, N. J.; C. S. Hoag and wife, of Bridgeport, Ct.; W. J. Martin and wife, of Pittsburg, Pa.; O. S. Runnells, Indianapolis; Miss Pennoyer, of Kenosha, Wis., and Drs. Corresta T. Canfield, Belle L. Reynolds and R. Ludlam, of Chicago.—Dr. A. J. Sawyer, of Monroe, Mich., was chosen President of the Institute.—Among the members of the Faculty of the "Old Hahnemann" who were present and participated in the meeting were Profs. Hawkes, Vilas, Hoyne, Leavitt, Laning, Shears, Bailey, Crawford, Ludlam, and its worthy old President, Dr. D. S. Smith.—For a copy of the new Catalogue for 1889-90, address Prof. E. S. Bailey, 3034 Michigan avenue, Chicago.—Dr. S. D. Low's address is 1861 Grant ave., Denver, Col.—Good locations for physicians of the right stamp can be secured by writing to Dr. J. O. Hoffman, Orleans, Neb.—The general Introductory to the Thirtieth Winter Session in the Hahnemann will be given on the evening of September 17th, by Prof. A. K. Crawford.—Several reports of interesting cases must lay over until our next issue.—No matter what magazines are showered upon your table during the dog-days, don't fail to read this issue of THE CLINIQUE carefully.

# HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

Winter Session of 1889-'90.

## ORDER OF THE MORNING AND AFTERNOON LECTURES AND CLINICS.

A. M.	MONDAY	TUESDAY	WEDN'SDAY	THURSDAY	FRIDAY	SATURDAY
8.30 . . .		Physiology, Prof. Cobb	Theory and Practice, Prof. Crawford	Clinic, Dental Surgery, Prof. Hoyt	Physiology, Prof. Cobb	
9.30 . . .	Anatomy, Prof. Halbert	Medical Chemistry, Prof. King	Anatomy, Prof. Halbert	Theory and Practice, Prof. Fellows	Medical Chemistry, Prof. King.	Anatomy, Prof. Halbert.
10.30 . . .	Clinic, Nervous Diseases, Prof. Fellows	Theory and Practice, Prof. Laning	Theory and Practice, Prof. Arnulphy	Clinic, Diseases of the Throat and Nose, Prof. Dunn	Clinic, Medical Diseases of Women, Prof. Bailey	Theory and Practice
11.30 . . .	Diseases of Women, Prof. Bailey	Clinic, Skin Diseases, Prof. Hoyne	Clinic, Surgical Diseases, of Women, P'f. Ludlam	Clinic, General Medical, P'f. Hawkes	Clinic, Diseases of Children, P'f. Leavitt	Clinic, General Medical, P'f. Laning
2.30 . . .	Clinic, Operative Surgery, Prof. Shears	Clinic, Eye & Ear, Prof. Watry	Obstetrics, Prof. Leavitt	Eye & Ear, Prof. Vilas	Obstetrics, Prof. Leavitt	
3.30 . . .		Materia Medica, Prof Gee	Surgery, Prof. Shears	Surgery, Prof Shears	Materia Medica, P'f. Hawkes	
4.30 . . .	Histology, Prof. Lyon	Histology, Prof. Lyon	Materia Medica, P'f. Hawkes	Sanitary Science, P'f. Gilman	Surgery, Dr. H. R. Chislett	

## ORDER OF THE CLINICS AND \*SUB-CLINICS.

	MONDAY	TUESDAY	WEDN'SDAY	THURSDAY	FRIDAY	SATURDAY
	Sub-Clinic, Surgical Dressings	Sub-Clinic, Surgical Dressings	Sub-Clinic, Surgical Dressings	Sub-Clinic, Surgical Dressings	Sub-Clinic, Surgical Dressings	
9.30 . . .	Anatomy	Medical Chemistry	Sub-Clinic, Diseases of the Throat and Nose, Prof. Dunn	Anatomy	Sub-Clinic, Diseases of the Throat and Nose, Prof. Dunn	Anatomy
10.30 . . .	Nervous Diseases	Theory and Practice	Theory and Practice	Throat and Nose	Diseases of Women	Theory and Practice
11.30 . . .	Diseases of Women.	Skin and Venereal	Surgical Diseases, of Women	Clinic, General Medical	Sub-Clinic, Diseases of Women, P'f. Bailey	Clinic, General Medical
1.30 . . .	Surgery	Sub Clinic, (12.30 P. M., Venereal	Obstetrics	Sub-Clinic Diseases of the Heart and Lungs, P. Arnulphy	Obstetrics	Sub-Clinic, Diseases of the Heart and Lungs, P. Arnulphy
2.30 . . .	Surgery	Sub Clinic, Prof. Hoyne (on call)	Sub-Clinic, Obstetrical Examina- tions and Diagnosis, Prof. Leavitt, (on call)	Sub-Clinic, Diseases of the Eye and Ear	Materia Medica	
3.30 . . .	Histology	Histology		Sanitary Science	Surgery	Sub-Clinic, Surgical Diseases of Women, P'f. Ludlam (on call)

\*Classes of ten students each attend these Clinics.





# THE CLINIQUE.

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VOL. X.]

CHICAGO, AUGUST 15, 1889.

[No. 8.]

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## Original Lectures.

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### *ALL DISEASES ARE DUE TO SOME LESION OF THE NERVOUS SYSTEM.*

A PAPER READ BEFORE THE ILLINOIS STATE HOMŒOPATHIC MEDICAL ASSOCIATION BY C. E. LANING, M. D., PROFESSOR OF CLINICAL MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

*(Concluded from page 248.)*

If micro-organisms ever *cause* disease, they do so through the influence which they exert upon the nervous system; and if remedies ever *cure* disease, they do so by virtue of their action upon the nerve centres. If the first proposition is correct, the second must be also; if the first is not, then the second cannot be true.

If remedies *have* cured many of the diseases now considered to be of germ origin, then they (the remedies), must have done so by virtue of their action on the nervous system; for it is irrational to presume that the attenuated form in which the remedy has been given in many alleged cures could have possibly mingled directly with the blood and so have killed the microbes, or at least rendered them incapable of doing further harm. And even if such a thing be admitted, how can we reconcile it with the fact that many different remedies have been found beneficial or curative in a germ disease, which, according to the germ

theory, must in each case have been caused by the same specific germ? Why should different remedies be given during the course of a zymotic disease? If the first stopped or held in abeyance certain symptoms, did it act by *destroying* a portion of the microbes, or by rendering them *all* less active. If it destroyed any, all being identically the same, why was not their destruction complete; and if it had such an effect upon them as to cause temporary benefit, why would not a repetition of the dose produce still further improvement—and if given sufficiently often, entirely dispose of them and cure the patient?

If diseases were really due to germs and were curable only through the destruction of the same, then would there be remedies specific for each disease, and only such germicides could be of avail.

There are no specifics for a given disease. Mercury in syphilis and quinine in malaria, perhaps, come the nearest to deserving this title; and yet every physician knows how far they fall short of filling the requirements of specifics. Quinine has been shown conclusively to destroy many micro-organisms, if it be present in exceedingly minute quantities in any fluid containing them. In spite of this fact there are many so-called germ diseases which it will not affect, and its frequent failure to cure malaria is notable.

It is claimed upon good authority, that men who work in mirror factories and whose duty it is to place the quicksilver on the back of the glass, never contract syphilis, and that those who work in copper, seldom or never are attacked by cholera. This looks as if these drugs might justly be claimed as specifics in the diseases which they seem *always* to prevent, and many times to cure. This view is fallacious and deceptive, for it is evident that many conditions or circumstances might so fortify the system as to enable it to successfully resist for at least a long time a given disease, yet if the disease had once seized the organism would prove entirely inadequate to its removal.

Hahnemann observed, that in many instances those persons who had made a thorough proving of a drug, were

rendered much less susceptible or entirely invulnerable to the attacks of diseases which when developed, give rise to the same or similar symptoms to those which had arisen during the proving of the drug. In short, those nerve centres which had been acted upon by the remedy, had acquired a power of resistance to morbid influences, greater than that possessed by them previously.

The explanation of the above facts is as follows: Any part of the organism, if extra work is put upon it, up to a certain point develops, increases in volume and power in order to meet the exigencies of the new demand. A muscle strengthens by having its task increased; but there are few who stop to realize that this development takes place *pari passu*, and as a result of nerve growth.

The gradual subjection of the entire nervous system or any part thereof, to the action of a drug which arouses its antagonism, beyond doubt increases the size and resistance of the parts acted upon, and if continued long enough, leaves them with a permanently augmented force. It is scarcely necessary to bring forward any evidence of this, and one illustration will answer. There are few who have not experienced the agonies of a first pipe, cigar, or chew of tobacco, and with rare exceptions, all have found that though the next attempt may have been postponed for years, nevertheless, the weed has not had the awfully energetic action that it did at first. Some may look upon this as an evidence of a weakening rather than a strengthening of the nerve power; considering that its resistance to the tobacco is less than at first. I do not believe this to be the true explanation nor to be sustained by analogy or facts. If tobacco or any drug is used beyond a certain limit, the nerve centres which have first resisted it, are finally overcome and weakened. If a heart which has undergone compensatory hypertrophy, in case of a valvular lesion, be taxed beyond a certain point, power developed as a result of the exaggerated work put upon it soon becomes lessened, and dilatation and almost entire loss of force follows. A nerve cell as well as a muscle develops power under increased

work, up to a given limit ; but one, as well as the other, weakens if an abnormal strain be too long kept upon it.

If syphilis and cholera are caused by germs or some subtle poison, and it seems as if we must accept one or the other as the exciting cause, how do copper and mercury prevent most cases and cure others? Do they remain in the blood and thus act as destructive agents to the syphilitic and choleraic poisons, or germs, as soon as they enter and so prevent their getting any lodgment in the system?

This can hardly be considered possible if all the facts of the case are taken into consideration. First, there is no evidence that either of these metals in any form or strength such as could be introduced into the body without injury, have the power to render harmless the micro-organisms which are possibly the cause of the diseases that they prevent and sometimes cure. That they possess germicidal properties is well known, but it is not proved that they act destructively upon the germs of syphilis and cholera respectively, and until it is, it is like giving aconite for all cases of fever, because it is good in some forms of it.

Secondly, admitting that both of these metals are germicides, there is no reason to suppose that the syphilitic or choleraic germs possess such a varying degree of resistance that in one case they are readily destroyed by these remedies, while in another they apparently are not affected in the least ; or if they do vary so that sometimes they resist these drugs and continue to ravage the system in spite of them, why is it that other remedies not possessing any germicidal properties, or at least not nearly in the same degree as those under discussion, are sufficient to accomplish what the cuprum and mercury failed to do—cure the patient.

If mercury simply comes in contact with the microbes, and by destroying them prevents or removes the symptoms which they would, or have produced, how is it and why is it that if the drug be introduced into the organism, when the germs are absent, it will give rise to almost identically the same conditions that the germs are supposed to? If it

acted in this way, then, as Bäumler has suggested, the "largest possible quantity of the drug that could be absorbed in the shortest possible time, would act the most certainly; whereas, we find that the opposite is the case, and that when, from large doses of mercury, salivation occurs, new localizations of the disease take place. The more nearly we approach to an utter avoidance of the physiological effects of mercury on the system, provided it exercises a sufficient influence on the manifestations of syphilis, the surer we are of obtaining beneficial results."

This serves to illustrate what has already been stated, viz.: that if a nerve cell be over-stimulated by a remedy, it becomes weaker instead of stronger, at least temporarily. Thus, the mercury which, if given in a certain quantity, increases the resistance of the tissues acted upon by the syphilitic poison when administered beyond a certain limit, weakens them, and "new localizations of the disease take place."

I believe that the whole explanation lies in the fact that, no matter what therapeutic method may be followed, the curative agent employed must reach the nerve centres that are affected and act upon them as a stimulus. When I say stimulus, I use the word not in the ordinary sense, but in the sense that resistance is a stimulus to a muscle, causing it to grow, that thought is to the brain, increasing its power, not a stimulus which compels the nerve cells to give up their force more rapidly than they can gain it, but one which obliges them to grow, to develop, and hence increases their power of resistance to any inimical agent. The whole universe represents the action of many antagonistic forces, and every *organic* body is so constructed that under certain conditions, and up to a certain limit, is able to increase its powers of resistance to forces opposed to it, which would, should they gain the ascendancy, cause serious harm to, or the destruction of the organized body, that is, its death. Why any poison or influence capable of so affecting a series of nerve centres, as to give rise to a definite group of symptoms identical with those produced by some drug,

will not also call forth their resistance to an equal degree with the drug is inexplicable.

It must be understood that there are many paths leading from various points of the body to a given group of nerve cells, and that although there must be a shortest and best route, we cannot always know which it is or which of our therapeutic agents will travel over it.

That a desired group of cells can be reached by various paths and various means, there is ample clinical proof. For not only may different drugs reach and affect the disordered nerve centres, but also other means may be successfully employed. To make this intelligible, it is necessary to be familiar with the fact that while nerves may be generally classified as motor and sensory, there are several subdivisions which play an important role in the economy. Thus, there are the excito-secretory, the reflex excito-secretory, the inhibitory-secretory and reflex-inhibitory-secretory, excito-motor, reflex excito-motor, inhibitory reflex-excito, inhibitory excito-motor, excito-vaso-motor, reflex-excito-vaso-motor, inhibitory-excito-vaso-motor, reflex-inhibitory-excito-vaso-motor, calorifacient nerves with their reflex excitor nerves and their direct and reflex inhibitory nerves, frigorific nerves with their accessories, the same as the foregoing, and last, but not least, the trophic nerves with direct and reflex connections.

These nerves, their functions, their paths, and the agents which act upon them all in a definite manner, present a vast field for study and experiment, and it behooves the physician who wishes to keep abreast of the times to know all that is known of them.

Let us now see how some of these nerves may be made of service to us in curing disease.

I have stated it as my belief, that tubercle, cancer and all forms of tumors are but so many evidences that the nerve centres controlling the tissue at the point where the abnormal growth has shown itself, are so affected as to cause a greater or less variation and modification of the physiological type of the cells constituting the tissue involved.

Are there facts which will sustain this theory? I think there are. If a tubercle is due to the presence of a microbe, and if the microbe or millions of them have selected a site in which to build up a colony of tubercles, what influences can be brought to bear to compel them to evacuate the premises? Can the nerve centres controlling the territory in which they are located be made to generate any force that will destroy them and drive them out of the system, or at least that position occupied by them at a given time; or must some substance, a germicide, capable of killing them on contact, be sent by way of the blood current to directly storm their fortifications?

And if the nerve centres are capable of disposing of microbe, tubercle, *et al.*, can they be made to do so only through a direct action upon them, or can they reflexly be so affected as to excite them to the proper action?

Can the above, not advanced in the shape of a theory, but merely as a question, be *answered* fully or in part by any facts in our possession? It certainly can.

There are a number of authentic cases in which it having become necessary to perform laparotomy, for the purpose of diagnosis and as the initiatory step to a possible operation, there has been revealed a peritoneum thickly studded with tubercles. It not being considered best to operate, the abdominal cavity has been closed until such time as might be deemed advisable to offer surgical interference for the removal of whatever growth may have been developing in the abdominal or pelvic cavity. Now, the point bearing upon the question before us is this: On opening the abdomen, after a varying length of time from its closure, every vestige of a tubercle had disappeared. Certainly the knife which had been used to perform the laparotomy in the first instance, could not have by contact or otherwise, directly destroyed all the microbes in all the tubercles. Neither can we refer their death to the direct effects of whatever antiseptics were used in making the primary incision, for in some of the cases absolute cleanliness was the only antiseptic precaution observed.



What could have induced this change, for even if the tubercles and microbes had only gone to some other part of the body, some force, some exciting cause must have been brought into play, of such a nature as to make it impossible for the microbes to longer continue their residence in the tissues of the peritoneum. Nothing but the influence of the nervous system upon the structures affected could have produced the results spoken of, and that such results have occurred there can be no doubt for of my own personal knowledge I know that such was the case in several patients operated upon by my colleague, Prof. Ludlam.

It now becomes necessary to call into action some of the nerves referred to above. Every area of the body has passing from it to the central nervous mechanism, nerves which when excited either inhibit, or intensify the action of the nerve cells which preside over the function and nutrition of that special region. Thus from any given point a message may be sent to the central nervous system, the reply to which may increase or diminish the amount of blood at the point from which the message was sent, or may increase nutrition or diminish it, or modify it in such a way that certain cells entering into the formation of the tissues at said point are multiplied out of their normal proportion and others lessened as in pseudo-hypertrophy; or still further, the nutrition of the part may be so modified that cells having entirely a different form and size are developed, which cells have not the power to perform the function of the original tissue. And still more, from any point may be sent a message which will raise or lower the temperature at that location, and that too without increasing or diminishing the amount of blood at said point, this being due to the action of what are called for the want of a better name, frigorific and calorificent nerves. Reflexly the secretion of a gland may be increased or diminished; the heart's impulse made stronger, weak, rapid or slow; the peristalsis of the intestines increased in force and frequency, or the reverse, and so on through the entire list of the organic functions. Enough has been stated I think, all of which we positively

know to be true, to sustain me in the point I now wish to make, viz: that the entire mechanism is under the control of opposing forces, the proper balancing of which constitutes the condition termed health.

If the cells entering into the formation of a given tissue at any time increase to beyond the normal number or size, the trophic centres controlling them are either acting in excess of what is normal, or the opposing centres, those which inhibit nutrition, are not acting up to normal.

It is positive that a tissue may hypertrophy or atrophy, without the nutritive qualities of the blood being in the least diminished, and as has been shown, not only may the nutritive changes be such as to increase or diminish the bulk of a given tissue, but also they may entirely change its character and weaken or destroy its functional activity. In case of all abnormal growths the problem is how to play one force against the other, for while tissue may be built up faster and differently from what is normal, it can if the proper means are employed, be unbuilt, so to speak, and made to assume a normal type.

The opening of the abdominal cavity in the cases referred to, through the irritation necessarily incident to the operation, and possibly kept up for some time by the sutures, reflexly inhibited the nerve centres which were causing abnormal tissue development in the peritoneum, and at the same time increased the activity of those whose function it is to destroy and cause to be carried away abnormal growths. If it seems remarkable that these results should happen through such apparently slight causes, and if it seems strange that the stimulus was sent to the proper centres entirely by a reflex route, it will not appear so I am sure, when one or two facts are taken into consideration. All of the nerve centres in the organism, with the possible exception of those concerned directly in the intellect, are caused to act, to throw out their force to the particular structures over which they preside, by reflex irritation. All the functions of the body, including nutritive changes, depend for their operation upon the integrity of the reflex mechanism.

The nerve centres being physiologically called into action reflexly, it stands to reason that they will be readily and powerfully influenced by agents that reached them through this route. There are many facts which prove this statement to be true. It nevertheless cannot be made easily available for the purpose of stimulating weak centres or inhibiting too powerfully acting ones, for the reason that the reflex circuits through which *effective* impulses can be sent must be carefully studied out, and as they differ widely for the various parts of the body, only a series of experiments based upon an accurate anatomical or physiological knowledge of the nervous system, can insure success in the application of any method of treatment which is destined to produce its results through the reflex mechanism. It is absolutely impossible to accomplish any wide range of cures by reflexes excited from a single given point. The entire body is a mass of intricate, though definite reflexes, the perfect knowledge of which will sometime enable the the physician to accomplish cures now considered impossible.

I have omitted a number of illustrations in the way of diseases, and considerable of my original paper on this subject, it being too voluminous for the present occasion, and have only attempted to include such portions as would tend to establish as a principle my statement and belief that "*All diseases are due to some lesion of the nervous system.*"

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## Clinical Society Transactions.

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H. N. LYON, M. D., SECRETARY.

JULY MEETING. 1889.

Because of the occurrence of a terrific thunderstorm the regular meeting of the Clinical Society, July 27, went by default. The following paper from the Bureau of the Diseases of the Eye and Ear, thanks to its able author, was ready for presentation, and is herewith given to our readers.

GLAUCOMA.—BY C. H. VILAS, M. D.—Glaucoma is one of the most dangerous and least generally understood of eye diseases. The insidious nature of its attack in the form most common, strikes no terror and misleads its victim, who fancies it to be some slight trouble, soon to pass away. Gradually tightening its folds, the meshes of the net are contracted until an almost hopeless entanglement binds its prey.

The causes are generally obscure, often never disclosed. It may result from heredity; mental emotions, such as prolonged grief, or any influence on the fifth nerve. Direct irritation of the ciliary nerves produces it; retinal hemorrhage is an indirect cause, and it is secondary to other diseases.

The almost certainty that badly or neglectfully treated, hopeless blindness will ensue, has stimulated ophthalmologists to its thorough study. Thus it has been found that hypermetropic eyes are most liable to its inroads, and that females at and about the menopause are highly susceptible, an attack on either eye almost certainly extending to its companion.

A fully declared glaucoma can easily be recognized by anyone, but it is a rare form of the disease, and may be confounded with a severe bilious attack, or a brain trouble

until too late for advantageous aid. But in this form its onset is so furious and of such an acute type of inflammation that it would seem that it should not be overlooked. In the chronic form a skilled eye will detect prodromal symptoms, such as a rapid increase of any existing presbyopia; colored rings around a light, the latter appearing as when seen in a foggy atmosphere; there may also be intermittent obscurations of sight, the intervals or periods of remission lasting days or months; more or less neuralgia, combined with the ciliary form; a variable slight increase of the intra-ocular tension, and a contraction or narrowing of the visual field, with dimness of vision.

Immediately before an acute attack these symptoms are intensified; it then bursts forth with the addition of severe headaches and terrible ciliary neuralgia, cloudiness of the aqueous and vitreous humors, dilatation and sluggishness of the pupil, which may be filled with a greenish reflex (whence the name of the disease) photophobia, lachrymation, and conjunctival congestion, fever and vomiting, and clouded cornea, the iris being jammed down against the cornea until the anterior chamber is obliterated. The distinguishing symptom, however, which is never lacking, is the increased tension, the eye perhaps becoming as hard as stone. Should a view of the fundus be obtainable, an unusual thing owing to the turbid condition of the humors and media generally, there will be found pulsation of the arteries, a swollen, beaded appearance of the veins, slight retinal hemorrhage, and most likely the cupping of the optic disc peculiar to the disease, of which more will be said later on.

But as I have said, this form is rare compared with the chronic form in which the disease generally invades the eye. A rarer form still is the *glaucoma fulminans*, or lightning glaucoma, which is the former greatly intensified. Under its stroke I have seen an eye wholly ruined in a few hours, and its baleful influence permanently stamped on the other. Happily such cases are rare. Under the chronic form the prodromal symptoms are usually mild, nearly always needlessly overlooked, and the disease crawls on, becoming

hopelessly incurable, or bursting into the acute form. The narrowing of the visual field may be the only symptom noted by the patient, or perchance an increase of an existing presbyopia, necessitating frequent visits to the optician. I have seen a case of confirmed glaucoma, absolutely hopeless, with blindness which knew no day and no night, and but this one latter symptom had ever been noticed by the victim. Any one of the symptoms noted should be regarded as suspicious, and competent aid at once sought. I let no case of eye disease, of a nature not thoroughly disclosed, pass through my hands without ascertaining the eye-tension, with a searching glance for this subtle foe of vision. A nebulous cornea, a dilated pupil, any uncertain symptom, and above all, a staphylomatous globe, may conceal this enemy, skulking in ever-shifting form, and hurrying on the eye to the absolute form, rendering the globe hard as stone, the pupil dilated, the lens opaque and green, the cornea dull and insensitive, and the anterior chamber shallow or obliterated.

The peculiar excavation of the optic nerve in this disease is highly distinctive, and can only be confounded with the physiological or the atrophic forms, which a little care would obviate.

Any symptom of all enumerated then, must be regarded as suspicious, and its cause and bearings ascertained. Hence it will not be necessary for me to declare that experienced judgment and training are essential to a mastery of this disease. I am not at all surprised that a physician, hastily summoned to a patient who is vomiting and loudly complaining of terrible hemicrania, and who shows no more injection of the eye than emesis produces, should think of many diseases before this one, especially as the patient may lay light stress on his disordered vision.

The age at which glaucoma is found, it being almost always a disease of middle life, may be misleading, though cases are not infrequent at an earlier age, and under certain conditions it may develop at an unusual age. A case which I have reported is, however, unmatched, and I will

read extracts from its history, as some may not have access to that periodical:\*

*Case.* August 4, 1888, Mrs. S., of Massachusetts, brought to my office her child, a bright and frolicsome boy. From her I elicited the following history of the case, which I relate in substantially her own words: "I am an American by birth, and so is my husband. I have never heard of any blindness or eye disease in either my own or my husband's family. My son was born on the 12th day of January, 1883, and, so far as I know, was in every way healthy, being so pronounced by the attending physician. I am certain he showed no defect in his eyes, because he was my first child, and I having had the sole care of him naturally frequently examined his eyes, as mothers do. Aside from the whooping cough at three months of age, there was never anything the matter with him until June, 1886, when I called the attention of my physician to an irritation of the child's lids. The physician made a prescription of some kind, but I did not use it, and do not think that the difficulty had anything to do with his present trouble. About a year later, in June or July, 1887, I noticed the pupil of his left eye was enlarged, as you see it in this photograph, which was taken in December following, and it has never resumed its former size. You can see by these other photographs I show you, taken at respectively six, eighteen and thirty months of age, that there was no trouble with the pupil then. Nothing further was noticed, and although I intended to take him to an oculist, I dreaded so to do it, I did not. About the middle of last March he went to bed one night as well as ever, but awakened in the night feverish and complaining of headache. I bathed his head and soothed him, but he was restless, afterward vomiting and complaining of headache and pain in the left eye and over the brow. His eyes were inflamed and he complained of the light, and wanted it moved. I called it a bilious attack. He lay quiet—almost stupid—the whole of the next day, so unlike him; and wouldn't open his eyes, grew more feverish, and wanted all the light shut out. A physician was then called. This attack lasted two days, when he opened his eyes some, but they were badly inflamed, and the physician advised seeing an oculist. Then there was an interval of about a month, when he had another

\*Archives of Ophthalmology, Vol. xvii, No. 4.

similar attack, though not so severe, the symptoms being limited to the head. He now seemed well, and I thought, as I was advised, that it was all over, though his sight did not seem bright. But about July 4th he had another attack similar to the first, not so severe, but very persistent. He did not recover so completely as before. I was thoroughly alarmed now, and sought among my acquaintances where to take him for further counsel, the result being that I am here."

I examined the patient carefully, finding the result as below, and at my request his mother allowed others to see the case also. I can give no idea of the difficulty had in making the examination, and the patience required, which must in a measure, account for my doubtful statements. I have never seen another such child, so frolicsome, so unrestrained, and so forgetful of the previous moment's caution. He cried furiously and instantly on the least restraint, and slipped about like a sea-serpent. I have since learned that withal he is very affectionate and kind, and popular with all he knows, but I was a stranger then.

**RIGHT EYE.**  $V = \text{about } \frac{1}{2} \frac{1}{8}$ . Refraction (by the ophthalmoscope),  $M = \frac{1}{8}$ . With correcting lens,  $V = \text{about } \frac{1}{8}$ , rather less. Pupil seemingly natural size, fairly movable. Iris sluggish but sensitive and infundibuliform. Subconjunctival veins tortuous and engorged. I could not detect arterial pulsations. Only slight turbidity of the humors. Tension markedly increased. (Glaucomatous cupping not detected, but found at a subsequent visit to be very plain).

**LEFT EYE.**  $V = 0$ . Refraction (by the ophthalmoscope),  $M = \frac{1}{2}$ . Pupil fully enlarged and immovable, the iris crowding into the anterior chamber. Vitreous turbid; excavation of optic nerve visible. But the lid drooped so quickly under the necessary light that the view was very unsatisfactory. Expression of the eye very dull, and the cornea insensitive. Subconjunctival veins much engorged. Extreme degree of tension.

I was about to leave for the train on a short vacation, and as no operation could be had without home correspondence, a solution of pilocarpine was ordered instilled in the eyes. From various imperative causes without my control, though pilocarpine, and after sufficient trial, eserine also, was systematically used, an operation was not available until September 4th, when the situation being substantially unchanged, I iridectomized each eye. The



cornea of the left eye was very hard, and the iris much congested; the right structures were less affected. The reaction in the right eye was almost nothing; the left was injected, dull, and heavy for about fourteen days. As to vision, the immediate condition was not materially changed from that before the operation; but the corneæ were sensitive, and the irides less sluggish, the right iris acting quite perfectly. Other changes incident to the changed tension, self-suggestive, were also present, but need not be detailed.

Nearly a year has now elapsed since the operation was performed. Sight has returned to the left eye, and the vision of the right has steadily improved. When last heard from the little patient was attending school.

I may say in passing that in the preceding number of this excellent publication a case of glaucoma at twenty-two years of age was deemed of sufficient rarity to warrant a record of its features, although no vision was present, recovered, or operation attempted.

The pathology is involved at present, and although being ably studied is too obscure for general dissemination.

Many operations for its relief have been proposed, but all have fallen into general disuse, save one, iridectomy. That one is so important that I have devoted a lecture to its elucidation,\* but shall briefly refer to it hereafter. To all such operations as sclerotomy, or the incision of the sclera so as to leave a narrow band at the top, the iris being allowed to remain intact; the gold drainage wire, etc., I shall do no more than to make a passing allusion, as the results of their use have been such that it is not likely that any will care to pursue them in their details. But there is one operation, that of paracentesis, which may prove of at least temporary value, often even more. In the early stages of this disease, if properly performed, it is often of the greatest value, and I am sure I have seen it suffice for treatment. It is also valuable after iridectomy has been performed. But it is not to be trusted unless its effects are immediate and promising.

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\* Reported in the CLINIQUE for November, 1880, Vol. I, page 361.

Care should always be used in the instillation of atropine into the eyes of patients over forty years of age; great care if there is detected the slightest tendency to glaucoma. A solution similar in strength of eserine or of pilocarpine should be used, say of two to four grains to the ounce of distilled water. Cases of an acute nature often do well under these local remedies, but they avail little in chronic cases.

General treatment is important. Moderate use of the eyes in recurrent attacks, cheerful surroundings and all that internal remedies and the tonics of air, sunshine and cheerful company will accomplish must not be neglected.

Among internal remedies

Belladonna has been found of use in relieving the flushed face and throbbing headache with sharp pains. The pupils are dilated, conjunctiva congested, with a general dry feeling, and much photophobia, also, when indicated.

Bryonia alba may be given when the eyes feel sore to the touch, and are generally worse on motion. Sharp, shooting pains through the globe may also demand this remedy.

Cimicifuga is valuable for the wandering pains which often change into other portions of the body.

Colocynthis has been used where the pains are better on pressure, but of a sharp, stitching nature.

Gelsemium is one of the most valuable of the remedies in this trouble, being often palliative of the severe pains, and seemingly exercising a curative influence on the neurotic character of the disease.

Phosphorus is useful in clearing up the vision after an iridectomy has been performed.

Spigelia has been found more valuable than any other one internal remedy for the alleviation of the sharp, shooting, and sticking pains which accompany this disease. These pains are worse on motion and at night.

Many more might be given, and doubtless others will be suggested by their concomitant symptoms. Too much re-

liance, however, should not be placed on internal remedies in a rapidly increasing glaucoma, or one which is terrible in its onset.

But for the relief of a fully declared glaucoma an iridectomy is usually necessary, and should not be delayed. So important an operation in its results I shall, as before intimated, spend a few moments in describing the best method of performing it.

A minute or two before operating, it is advisable to instill into the conjunctival sac a drop or two of a two per cent. solution of cocaine. A good speculum should be selected. I prefer one like Von Graefe's, because it raises the lids as well as opens them, and does not rest on the globe. The ordinary wire speculum is not a safe one for this operation. After the speculum is adjusted, an assistant should hold the head firmly between his hands, when the conjunctiva may be seized with a pair of fixation forceps and the eye rotated to the desired position.

The incision should now be made with either a keratome or a long knife. It is important that the iris be not pricked or the anterior capsule wounded, or the benefits of the operation may be lost. The incision made, the operator may dispense with the fixation forceps, or pass them to an assistant to hold the eye as desired. Now introduce the iris forceps, seize a suitable amount of iris, draw it out and snip it off with the iris scissors. If the iris becomes entangled in the corners of the wound, remove it, but do not poke around on suspicion. Remove the speculum, soak up the aqueous humor with a bit of soft rag, and pad and bandage both eyes.

A single operation may not prove sufficient, in which case the opposite segment of the iris should be removed at the next operation, or a paracentesis made.

Judgment and experience must be made to play the parts demanded in surgery, and without which the best operations fail. By their use seemingly hopeless cases may be restored in part at least, and irremediable blindness averted.



SPECIMEN FROM EXTRA-UTERINE PREGNANCY.



VOLUNTEER PAPERS. I. EXTRA-UTERINE PREGNANCY, LAPAROTOMY, REMOVAL OF THE FETUS AND PLACENTA. DEATH AFTER THIRTY HOURS.—By DR. E. STILLMAN BAILEY.

*Case.*—Mrs. B., aged twenty-six years, mother of three children—the eldest eight years, the youngest three years. Her former pregnancies were normal and the labors unusually easy. She always has enjoyed excellent health up to this last illness. The brief history is as follows: March 15, 1889, menstruation was normal in every respect. April 14th, menstruation was established, but it was very scanty and unnatural; lasted scarcely two days, and was very much changed from normal in every way. April 30th, was taken with excruciating pain; the onset was sudden and without a known cause, but it rapidly progressed in severity, causing syncope, palor, cold sweat, and threatened collapse. This condition lasted four hours. The two days following, the same symptoms were repeated, though in lessened severity. A small swelling in the left illiac fossa was noticed at this time. Many of the same symptoms were present for the next ten days, when the patient had a movement of the bowels, there being “a hard lump” that had to be pushed upward in order to get relief.

May 10th. I saw the patient for the first time. She was about to menstruate, and had the same kind of symptoms as at the two preceding months. The menses were scanty and the tumor in the left side, low in the groin, became very distinct, irregular in size, hard and quite painful without, as well as with, the touch. The diagnosis of extra-uterine foetation was made at this date. Until July 14 she improved gradually, and did not have a return of the symptoms as above described, except in slight degree.

July 15th. Menses as for four months; great pain and jerking of the left leg, causing her to get out of bed instantly; restless sleep, the tumor rapidly enlarging.

July 16th. Another bad night; no sleep, jerking and numbness of left side. The tumor has grown rapidly, and now is to be found in the median line and directly central, and the shape not unlike the crown of a Derby hat.

Prof. Ludlam, having been my consultant, advised a resort to laparotomy, and July 17, at 4 p. m., after the patient had had a wretched day and night, it was accordingly performed by him.

*Remarks by DR. LUDLAM.*—As Dr. Bailey has requested, I will add a few notes concerning the operation. There

were present Drs. Bailey, G. F. Shears, D. H. Williams and R. Ludlam, Jr. The first point of interest was the site of the placenta, which was directly in front, along the mesian line, and beneath the abdominal wall. For this reason, when it was exposed the tumor had the appearance of a very vascular and malignant sarcoma. Its central position and prominence, its size, dark color and friable texture, as well as the impossibility of feeling anything like a fœtus through it were very misleading. By the most delicate manipulation the worst possible hæmorrhage was started, and would have been fatal but for the ready use of several pairs of Péan's larger forceps. When this had been attended to and the parts cleansed, I opened the gestation sac, and the first thing to escape was the fœtus, which was about four inches in length. Then I found the sac to be filled with old, bronzed blood-clots, of which enough were quickly scooped out to fill a common wash-bowl. The placenta was removed and the sac was filled with hot sponges, the edges being guarded by the hæmostatic forceps; and when the hæmorrhage had been arrested and the parts thoroughly cleansed, the wound was carefully closed, a glass drainage tube being left at its lower angle. (See the cut.)

The second point of interest was the hæmatocele which had occurred within the extra-uterine gravid cyst. But for it I am satisfied the patient stood a good chance of recovery, even though the placenta was placed in the worst possible position for a successful operation. No doubt this concealed hæmorrhage, which, judging from the blood-clots contained in the sac must have been very severe, was sufficient to account for the suffering and the collapse referred to in Dr. Bailey's notes of the case. The indications for operation were imperative, but the result affords another illustration of the truism which holds that "the resources of surgery are rarely successful when practiced on the dying."

*Apropos* of finding the placenta located in a line with the abdominal incision in this case, I may remind the members of this Society that although such an accident is comparatively rare (the proportion, according to Lusk and others, being one in six cases), I have encountered it in three of the cases of ectopic gestation upon which I have operated. Two years ago, (September 24, 1887), I cut down upon a very large tumor, in the case of a patient of my friend, Dr. J. B. Backus, of Braidwood. It was one of

ectopic gestation, the pregnancy being far advanced, the trouble having been properly diagnosticated by Dr. B. some weeks before.

There was an unfortunate delay in my arrival, and meanwhile the poor woman had a terrible attack of peritonitis, with collapse of her strength and threatening dissolution. She was kept alive by the doctor's assiduous attention during the night previous to the operation. The case was a desperate one, and coming down upon the tumor the whole appearance to the sight and touch was that of a very large and very malignant sarcoma. I could feel nothing like a fœtus, through it or around it, and knowing from experience how such tumors sometimes bleed from puncture, I would not venture to pass an exploring needle into it. The consequence was that my diagnosis did not agree with that which Dr. Backus had made long enough before my incision, and the wound was closed, the patient being almost in *articulo mortis*. She died the next day and the autopsy made by my son and Dr. Backus disclosed a retro-placental fœtus of at least six months.

For these and other reasons which might be adduced, I am inclined to think that the matter of cutting down upon a gestation sac, unless it be in the pre-rupture stage, when there is no sac to speak of, no placenta, and no hæmatocele, is a very serious affair and should not be lightly undertaken.

2. EPISIOTOMY UNNECESSARY—By A. A. WHIPPLE, M.D., Quincy, Ill.\*—Much has been written in regard to the necessary care of the perineum during the passage of the head through the vulvar orifice, and many methods of prevention have been devised and recommended by obstetricians. In nearly every work on obstetrics the practitioner is advised to endeavor to prevent laceration by the manœuvre that is usually described as “supporting the perineum.” By this is meant laying the palm of the hand on the distended structures and pressing firmly upon them during the pain, with the view of mechanically preventing their tearing.

Error may be traced to a misconception of what is required. This term conveys an erroneous idea, for certainly no one can prevent lacerations by support of the perineum,

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\* Read before the Illinois Homœopathic Medical Association.



If the term relaxation were employed, we would have a more accurate idea of what should be aimed at; and if this is borne in mind, I think it cannot be questioned that nature may be usefully assisted at this stage of labor.

Among the many causes for perineal lacerations we find unfavorable position and size of the head; too early extension in occipito-anterior, and insufficient flexion in occipito-posterior positions; injudicious voluntary efforts; rigidity of the perineal tissues; the improper use of ergot; awkward handling with injudicious and hasty traction in forceps cases, to be a few of the many causes. But more than all is the want of judgment, mechanical skill, or good common sense on the part of the physician who presides over the delivery.

"With care you can lead an elephant by a hair, but you musn't yank." Perineal rupture is not always an evidence of unskillful management, and yet it is clear to my mind that measures directed to the support of the perineum without removal or arrest of the cause, must prove ineffective. Laceration of the perineum would be a rare accident were the rule to support it during the latter part of the second stage entirely dispensed with in obstetrical practice. The care of the perineum consists in omitting the interferences that cause injury. Omit the improper use of ergot and manipulations that excite reflex forces; suspend the injudicious voluntary efforts at the proper time; correct the defects of position, of flexion and extension. These suggestions refer to the removal, lessening and arrest of the causes, and not to the propping up of an attenuated and fragile tissue, while the forces or causes are continuously operating with increasing intensity.

In my opinion, the best way to prevent lacerations is to prevent a rapid termination of the second stage of labor, thus giving the perineal muscles and other tissues time and opportunity to relax. This can be accomplished in natural labor by retarding the advance of the head at the last moment, when the perineum is distended to its utmost, at the same time asking the mother to cease bearing down.

As this time draws near I usually explain to the patient

what I wish her to do, and why. A short delay at this time gives the distended tissues opportunity to stretch, and the head will pass without tearing, when otherwise the combined voluntary and involuntary expulsive efforts will force it through, often at the expense of a ruptured perineum. By the use of forceps we can subserve the purposes of delay more effectually than without them. They are the most useful and beneficial instruments in the physician's armamentarium—instruments which, in skillful hands, and with proper care and judgment, can never do harm to mother or child, and will often be the only means of saving the life of one or the other, or both, or of sparing the mother the consequences of delayed delivery and excessive pressure of the soft parts. The operator, by the exercise of a moderate force of resistance, can slow the exit of the head, and thereby avoid injury.

One of the most fallacious of all the methods devised by the physicians or obstetricians to prevent laceration since Hippocrates was a baby is that of episiotomy.

To prevent serious lacerations of the perineum, some have advised that one or more lateral incisions be made with a pair of blunt-pointed scissors or a probe-pointed bistouri. This may no doubt be done with safety, but I question its utility.

It is said by those who look with favor upon this little operation, that an incised wound will heal more readily than a lacerated one. It is my opinion, however, that when a distended perineum ruptures, its structures are so thinned that the tear is always linear, and as a matter of fact, the edges of the tear are always as clean, and as closely in apposition as if the cut had been made with a knife, and will heal perfectly if the edges are brought into contact and held there with sutures.

I see no reason to anticipate a tear, and therefore believe we are not justified in resorting to perineal incisions when we do not know beforehand in any given case whether laceration will take place or not. The greater number will

escape without rupture, and those that do not should be cleansed and the rent closed by sutures immediately.

The physician should never attend a woman in confinement and leave the room without first having learned by actual observation with a good light, whether rupture has taken place or not. If you do, you will sooner or later be surprised and humiliated by the nurse telling you that the woman is torn. It is careless practice, to say the least, to let the nurse be the first one to learn of this condition.

In the *résumé* of a recent paper by Dr. T. G. Comstock, on occipito-posterior positions,\* speaking of perineal lacerations, he says, "when such cases occur and we cannot deliver without the forceps, I would propose that lateral sections of the perineum be made (episiotomy), and then the delivery can be accomplished."

At the time this paper of Dr. Comstock's was read, and while under discussion†, a letter was introduced from Dr. Phil. Porter, giving his opinion as follows: "Yes, I have resorted to episiotomy three times in my practice, and although there was no rupture of the perineum I was in doubt whether there would have been had I not employed episiotomy. In one case there followed phlebitis, and later sloughing of the entire labial portion, giving me an ugly wound to treat. The other cases, while they presented no trouble, raised a question of doubt in the minds of the patient and her friends as to its benefits, etc.

"Any surgical operation that necessitates an apology every time it is resorted to, and has associated with it doubt, seldom if ever, becomes popular; at least I am satisfied, and shall not resort to it again without there are some unusual reasons."

In the same discussion Dr. R. Ludlam very hesitatingly and cautiously admits that, under certain extreme conditions, "*It may be an available resource.*" "The worst of it is (he says), that the warrant for resorting to it is not what

\* Transactions of the Clinical Society of the Hahnemann Hospital, of Chicago, December, 1888.

† Vide the CLINIQUE, Vol. x, page 19, *et seq.*

it should be, unless we are morally certain that the labor could not be satisfactorily finished without it—and such a conclusion is not always possible.”

The operation of episiotomy is, in my opinion, unnecessary and meddlesome, and should be unhesitatingly and absolutely rejected as unscientific and irrational, and consigned to the same oblivion to which the operation of symphysiotomy has already been assigned.

3. A CASE OF ACRANIA.—BY DR. C. V. HINMAN, of Fort Scott, Kansas.—*Case.* I was called at 2:30 a. m., December 23, to attend Mrs. — in confinement. She was a primipara, aged 16 years and 6 months, and had been having fugitive pains since noon of the day before. I found the pains coming at regular intervals of ten minutes, the os dilated to the size of a silver dollar and the membranes protruding fully two inches, forming a true bag of waters; but I could not feel any presenting part between the pains, because of the tenseness of the membranes. As the case was making very little progress the membranes were punctured with a probe and an immense quantity of amniotic fluid drained off. I could then feel the fœtus presenting, but on endeavoring to diagnose the presentation, it was drawn spasmodically upward out of reach. In about an hour the pains began again and I then found the face presenting at the superior strait in the second position, and as it was freely movable I endeavored to alter the presentation by upward pressure on the chin. I succeeded easily enough but as soon as pressure was removed the face would immediately come down again. This was done several times, and I concluded to let it go as it wanted to, and everything progressed favorably but slowly.

The excessive quantity of amniotic fluid, and the fact of the face always returning, led me to mistrust a monstrosity, and when the child was born I found that from the coronal suture to the base of the occiput there was no brain substance; the parietal bones were formed but were tipped inward and lying flat on the inner surface of the occipital bone; the scalp was drawn tight over them, and had a slight growth of hair. At the site of the posterior fontanelle there was an opening of about three-fourths of an inch in diameter, from which protruded two loops of tissue about an inch long and three-eighths of an inch in diameter, resembling two large angle-worms. The rest of the

foetus was fully developed and apparently healthy ; it cried as soon as born, breathing naturally, and lived fifty-six hours.

Nothing could be discovered from the history of the pregnancy that would be likely to produce the condition as a mark. The mother had received no fright or accident of any kind, and had even escaped the usual morning sickness.

4. CHRONIC CATARRHAL INFLAMMATION OF THE MIDDLE EAR—BY G. B. BUSHEE, M.D., OF ENGLEWOOD, ILL.—*Case*—This case presented May 6, 1889. The patient, Albert H., æt. 10 years, complained of the following subjective symptoms : Tinnitus aurium, pain, paroxysmal vertigo, and of hearing better in a noise. The objective symptoms were : A free mucous discharge from the right ear, the manubrium of the malleus was foreshortened, the tissues about the ear were flushed, there was a slight pharyngitis and very little cerumen.

It was certainly a chronic case for one so young, as he had been similarly affected for nine years whenever he "took cold," which he was very liable to do during the least change in the weather. He has been treated most of the time and during the past two years by a prominent aurist, with but temporary relief at best.

The disease was not a sequela of any of the eruptive troubles of childhood, but the father is subject to catarrh, and there are other traces of hereditary cause. The lesion has not been associated with other diseases, as is so often the case, as the boy otherwise is in very good health.

The treatment consisted in syringing the ear till free of discharge with a  $\frac{1}{10000}$  solution of *Merc. bich.*, spraying the ear, nostril and throat with a saturated solution of Boracic acid, and inflating the middle ear with Politzer's air-bag. In addition the battery was used. The Faradic current was employed, primary coil, the positive pole being placed upon the affected ear and the negative upon the other. *Pulsatilla* was given internally. The improvement was marked from the first, and upon the second day after the first treatment there was no discharge apparent. The vertigo decreased, also the ringing in the ears, the pharyngitis, the flushing of the tissues, and the hearing improved rapidly. While he could hear scarcely any in the right ear at first, he now hears forty-six inches in that ear. Only fourteen treatments were given, and while he had an attack of pharyngitis during the latter part of May (when it rained so continuously), there was no apparent affection

of the ear—for the first time in years. The last treatment was given June 12, but he has received *Kali bich.* internally until recently. He also received *Ars.* and *Nux.* while he was taking treatments. The other ear has been slightly affected, as is usual in such cases.

The result in this case I attribute largely to the use of electricity, for the other agents used were doubtless quite similar to those used by others. But electricity had not been used previously, so far as I could learn. It is not a common remedy in this class of cases, but why should it not be used? For there are certainly nervous features due to nutrient disturbances in the nerves of the middle and internal ears, induced by the catarrh. The vertigo is caused in that way by under pressure upon the labyrinth fluid, that in turn setting the nerve of hearing in motion, and that the cerebro-spinal fluid, and so through motor-fibres of the auditory nerve causing the vertigo. The flushing of the tissues about the ear also shows a disturbance of sympathetic and other nerves. And although the nervous symptoms appear secondary to the catarrh, why not treat them first, according to the law of Hahnemann? Electricity has, also, been used with good results. Those opposed to its use claim that other means answer as well, but I believe in "proving all things and holding fast to that which is good." The idea has been advanced that "*the body is constructed by the nerve system,*" and that a man is really a nerve system clothed in flesh, and not, as we are accustomed to think of him, a structure of bones and flesh permeated by nerves. Again, in speaking of vital force: "What that Vital Force is: if it be identical with, or allied to electricity or magnetism, or to any other of the known forces, merely being modified by its connection with organic structure, we are as yet ignorant."

For the homœopathic practitioner especially, the nervous symptoms should be of prime importance.

This case is not permanently cured, but considering its chronic nature, the age, and the improvement that has been made, I believe he is as nearly cured as he will ever be in this climate where he is exposed to such sudden and severe changes in the weather.

5. EPILEPSY, HYSTERIA AND MORPHINOMANIA. EXTRACTS FROM A RECENT CLINICAL LECTURE BY CHARCOT. TRANSLATED BY R. LUDLAM, JR., M. D.

The patient before you presents three distinct affections for your consideration, which are superimposed and com-

bined without modifying each other. The first of these is genuine epilepsy, the second is hystero-epilepsy, and the third is an artificial, or toxic neurosis, *i. e.*, morphinomania. It is evident that these conditions form a complex which at first seems inextricable, but we are going to try, by a delicate analysis, to separate them and to show you that there is no blending between them, nor hybridity; and that these three diseases appeared simultaneously but independently of each other.

This man has nothing peculiar in appearance; he is small, stubby, but rather solid; his expression is sad, and he appears dejected. There is nothing special in this latter symptom, for we know that he is addicted to the morphine habit. His hereditary antecedents are curious. He is the son of a consumptive father and of an epileptic mother; one of his uncles is insane; there are two sisters, one of whom is free from any nervous affection, but the other is an epileptic. Further back in the family we find that the mother's brother was very nervous. This is sufficient to show you that he comes from a highly neurotic family.

At the age of seven years he began to have spasms at night during which he would bite his tongue, and urinate in the bed, and these attacks would recur two or three times a week. Under the influence of the bromides they became less frequent, and this is a peculiarity to which I wish to call your attention, because it belongs to true epilepsy. He took the bromides at intervals until his twentieth year, at which time he was seized with typhoid fever with serious cerebral complications, and the convalescence from which was long and painful. Upon the return of the spasms, which were more severe, he became very melancholy, and it was in this state that we first saw him. That it is epilepsy I have not a doubt. These fits came on at night without his being able to recollect them in the morning. The absence of the prodroma, the biting of the tongue, the soiled bed, are certain symptoms of epilepsy. Guided by the labors of Lepine and Mairet, Mr. Gilles, of Tourette, my *Chef de clinique*, has examined the urine for the nutritive waste, and he has found that after these spasms the excretion of urea was from 21 to 36½ grammes, and that of the phosphates from 2 to 2.65 gr. We have long since noted a marked elevation of the temperature in epilepsy. The increase of the nutritive waste, which we do not find in hystero-epilepsy, shows us that there is nothing in common between these two affections. We have here a

typical epilepsy which does not seem to be influenced by the hysteria, or by the morphinomania, but nevertheless, the existence of these two nervous affections, added to the epilepsy coming in the same person, cannot be doubted. Let us inquire in regard to the hysteria.

This man is entirely anæsthetic and analgesic. Except on the bottoms of his feet, where the sensibility is simply weakened, he has lost the sensibility of his whole surface. Below the umbilicus it is exaggerated, but we shall speak of that directly. Neither pricking with a pin, nor heat, nor cold are felt by him, there being complete anæsthesia. The muscular senses are affected, but not entirely destroyed; he stands erect with his eyes closed, but the idea of the position of his hands is lost. Here is a series of symptoms that you will not find in epilepsy, but although you can find them in certain organic diseases, as for example, in *syringomyelie*, it should make you think of hysteria first. This man has completely lost the sense of taste and smell; his hearing is obtuse, and what is more significant, his vision is considerably shortened.

This anæsthesia and narrowing of the field of vision are specific symptoms of hysteria. It has been said, by Mr. Oppenheim (of Berlin) especially, that these symptoms may also be found in epileptics. But I have already explained that in such cases a careful research always discloses, in connection with epilepsy, other signs of hysteria, even when no true paroxysms exist.

Concerning the zone of hyperæsthesia below the umbilicus, of which I have already spoken, we have a zone of general hyperæsthesia and also the two plaques which correspond to the two ovarian regions in women, and which can be considered as veritable hysterogenetic centres. If I make slight pressure in this region, the eyes of the patient become fixed and staring, his speech is broken, he complains of beatings in the head, and there appears before his eyes an illuminated cog-wheel that appears to be a scintillating spot. Doubtless by continuing this pressure I might provoke a paroxysm, and this would be a paroxysm of hysteria and not a fit of epilepsy, for one cannot provoke the latter at will. \* \* \* \* \*

(To be continued.)



## Hospital Notes.

### THE CHILDREN'S CLINIC.

#### SERVICE OF PROF. LEAVITT.

*Case 11026.* James C., æt. 1½ years. Is irritable; does not sleep well; has pain in the bowels, with thin, greenish, watery stools. *Merc. cor.* afforded relief.

*Case 11028.* Lulu D., æt. 2 years. Had cholera infantum eight or nine months ago, since which she has not been well. Is very fretful; restless at night with fitful sleep. Dry eruption on the scalp. Stools yellow and curdy, with several daily movements. *Ars. jod.*

A week later there was slight improvement, and the same remedy was given in a higher potency, with relief.

Three months afterward the same patient was presented. Was just recovering from measles. Cough still continued. Was very weak; had poor appetite; great thirst; poor sleep; restlessness and uneasiness during the day. *Ars. jod.* again cured.

*Case 11031.* Mary K., æt. one week; cachectic, feeble-looking child. Is nursed nearly all the time for sedative effect. Bowels loose. *Sulphur* was prescribed, and the mother enjoined to lengthen the intervals of nursing to an hour and a half. The result was decided improvement.

*Case 11033.* Daisy C., æt. 10 years. Has had headache in sinciput for more than a year. Is nervous and has poor appetite. Tonsils enlarged. *Iodium* was given, and a week later she reported a good appetite and marked improvement in the headache. The same remedy was continued, and the patient did not again report.

*Case 11041.* Irene B., æt. 22 months. Fell from a chair the preceding day, striking on the back of the head. Vomited during the night; has not urinated since last evening; somewhat listless; pupils rather large; pulse slightly accelerated.

The appearance of this child led me to fear cerebral inflammation. The impression was doubtless more vivid because I had recently lost a case from meningitis, set up by a similar fall. *Belladonna* was prescribed. I subsequently learned that, for two or three days, the symptoms were intensified, and then they rapidly disappeared.

*Case 11045.* Samuel F., æt. 11 years. Two months ago had a sore throat, which, I have no doubt, was diphtheritic. Now walks with a slow, dragging step; strangles in attempting to swallow liquids; is emaciated. There is drooping of the soft palate, and fetid breath. *Arsenicum jod.* was given, and continued for four weeks, with much improvement. He was then able to swallow without difficulty, and could walk quite rapidly, but was pretty likely to fall when attempting to run. *Conium* was given for two weeks, when the record reads: "Improving. Complains of no pain. Plays and eats well." The concluding remedy was *sulphur*.

*Case 11052.* Frank S., æt 11 years. Came to me from Prof. Shears' clinic, where he had received treatment for the immediate results of a severe fall on stone steps, which happened some weeks ago. Has complained lately of pain in the right leg and thigh, more severe in damp weather, for which he has received *rhus tox.*, but without much improvement. His nostrils look sore, and there is herpes on the lips. The first remedy he received from me was *natrum mur.*

A week later he reported diminished pain in the leg, and the nose and mouth were much better. Still he felt little disposed to play; his appetite was poor; he had headache and thirst. *Arsenicum alb.* was given.

The next week he reported a return of the pain in both legs, worse toward evening. Had diarrhœa all the week, with soreness in the rectum. Stools dark, and not very thin. Had slept better. *Rhus tox* was again given, and continued for two weeks with some improvement. He felt more like playing. Appetite was poor; but he had considerable thirst. Epigastrium seemed abnormally full. Sleep was quiet, and he had no pain. *Calc. carb.* Seven days subsequently he was better, and received a placebo. After a fortnight he returned with headache, and said he had been vomiting his food. All I gave him was one dose of *sulphur*. An the end of another month he reported himself entirely well.

*Case 11061.* George B., æt. 14 months. Bowels very loose; is very restless; wants to move all the time. He has ten teeth. *Arsenicum alb.* The succeeding week found the bowels still very diarrhœic, but the sleep was better, and the nursing had been regulated. Perspires freely all over. *Mercurius jod.* was prescribed, and as he had returned nearly to a normal condition, seven days later a higher potency of the same remedy was given to complete the cure.

## Miscellaneous Items.

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The Thirteenth Annual Catalogue of the Old Hahnemann Medical College and Hospital is out, and can be had by addressing Prof. Bailey, 3034 Michigan Ave., Chicago. —Prof. Hall, Leavitt, Watry and Gee are at home from a brief holiday. —Prof. Vilas, Dr. Hanna, the house physician, and Profs. Halbert, Hoyne and Shears are “outing” it, and Profs. Crawford and Lyons will “assist” at the National Microscopical Society in Buffalo. —Dr. O. W. Carlson, 1872, has resigned the medical charge of the Protestant Orphan Asylum in Milwaukee, a post that he has filled most acceptably and honorably for fifteen years, in favor of Dr. F. C. John, 1880. —The Western Academy of Homœopathy, of which Prof. Hoyne is the President and Dr. W. A. Paul, 1881, Vice-Prest., will meet in Rock Island, Ill., Aug. 28-30. —There is a good prospect for a rousing class in the Old Hahnemann next winter. —We are to have a Pasteur Institute in Chicago very soon, which is news for the little dogs that have been barking at the famous Parisian. —Our sympathies are with Dr. Reed, of the *Medical Investigator*, because of the death of his wife. —All the old boys and girls too, who have been about the clinical farm at the Old Hahnemann within the past decade will be glad to know that Dr. H. R. Chislett, formerly House Surgeon, has been chosen an adjunct to the chair of Surgery. —Hon. Erskine M. Phelps, one of our Board of Trustees, has returned safely from a protracted visit to the American Minister at St. Petersburg. —“When a thing is true it can be made intelligible, but it is not always true because it is intelligible.” —Dr. C. N. Hart, of Denver, writes a very pleasant letter from London for which, unfortunately, we have no space. —Dr. Alice A. Ewing, 1887, has returned from her mission to Johnstown, Pa.

# THE CLINIQUE.

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## Original Lectures.

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### *SOME ANOMALOUS AFFECTIONS OF THE URINARY ORGANS IN WOMEN.*

A PAPER PRESENTED THE AMERICAN INSTITUTE OF HOMŒOPATHY, JUNE, 1889, BY R. LUDLAM, M. D., PROFESSOR OF SURGICAL GYNECOLOGY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

In women, contrary to what occurs in men, the non-inflammatory affections of the bladder are by far the most frequent. This fact has its clinical explanation in the peculiarity of their sexual organization, and in their consequent susceptibility to certain causes of urinary mischief, the most of which either do not exist or are harmless in men.

And not only are these distressing affections more frequent and varied in the class of patients which belong to our specialty than in those of the opposite sex, but we find that they are less easily differentiated and more difficult of cure. The reason for this lies in the fact that the relations between the structure and the functions of the bladder are not of a fixed character. If they were, and if we could always identify the lesion as we may do in the forms of cystitis that have already been considered, the pathology of these cases would be easily explained, and they would be more readily cured.

There is no point in gynecological practice in which, at the outset, it is more important to disabuse one's mind of the supposed necessary relation between the inflammatory process, or its consequences, and local disease and suffering from other very different sources. On the basis of a large experience, I am confident that we ought to discriminate most carefully in obscure and obstinate affections of the urinary organs in women to the end that we may apply the proper means of cure, whether they be medical or surgical, most skillfully and successfully.

With a view to facilitate the study of this class of cases, and to warn my medical friends against the folly of treating them by a routine method, I most respectfully submit the following considerations:

Within the scope of this paper an anomalous affection of the urinary organs is one which deviates from the rule that a serious perversion of function must necessarily be accompanied by a change of structure. Most of these cases were formerly classified under the general head of irritability of the bladder, because there was no constant or consequent lesion of its tissues. And although, as in the case of Gooch's "irritable uterus," the word *irritability* has now lost very much of its clinical import, we may yet do well to retain it in connection with vesical troubles especially, and as a safeguard against the inflammatory *ignis fatuus*, which has so often put the physician on the wrong course of treatment.

The limited number and the similarity of the symptoms, as well as the varied causes of this order of urinary affections, have been so many stumbling blocks in the way of their cure. For they often bear so close a resemblance to those of organic disease as to be extremely deceptive and misleading. Indeed, without a recognition of the peculiar cause upon which a given case of this kind may possibly depend, its clinical portrait cannot be accurately drawn, nor can we prescribe for it intelligently. We need to know the source of the mischief before these equivocal symptoms can have their proper therapeutical significance. For not

only are there "no liars like our own sensations," but there are no vesical symptoms of the subjective sort that will point to the remedy for the knotty cases of which I am speaking, and which depend upon such causes as we must now hasten to consider.

ETIOLOGY.—There are four classes of causes for these peculiar affections of the urinary organs in women: (1) the intra-vesical and urethral; (2) the mechanical; (3) the reflex; and (4) the constitutional.

1. *The Intra-Vesical and Urethral Causes.*—In some cases the muscular coat of the bladder is especially involved, and the organ becomes intolerant of the smallest quantity of urine, which is voided with pain, or there are painful contractions after the flow. Here the symptoms that are due to a spasm at the neck of the bladder depend upon an irritable condition of its so-called sphincter, and of its muscular walls, which may be excited to contraction by the presence of a calculus, or of some foreign body within the organ or the urethra. Sometimes this muscular irritability is rheumatic, sometimes it is choreic, but more often it is hysterical and reflex. It causes strangury, and may induce the stammering of the bladder so cleverly described by Paget. It sometimes exists for months without giving rise to any settled disease.

The mucous coat of the bladder, as well as of the urethra, is so delicate and may become so very sensitive as not to endure the contact of a considerable quantity of urine, more especially at night, in excitable conditions of the mind, and in case of bodily fatigue. This condition of hyperæsthesia of the vesical lining is most frequent in highly neurotic subjects. There are also instances in which the quality and not the mere quantity of the secretion is mischievous. It is not very unusual for the suffering to depend upon a sharp acidity, or a decided alkalinity of the urine, or upon oxaluria that is easily remedied. Some of the best cures that I have ever made in these cases have depended upon the detection of sugar in the urine, a condition that is more often post-puerperal than otherwise.

In young and very hysterical women a temporary diabetes insipidus may have the same effect, the distension of the bladder increasing the desire and the necessity for the discharge of its contents.

With the approach of the menopause we not unfrequently find that women complain of vague pains in the hips and in the hypogastrium, and of pains that radiate from the meatus urinarius; pains in the region of the bladder and the vulva, that are drawing, and intermittent, and that interfere with walking, exercise, and coitus. In these cases the flow of urine is followed by smarting and by the loss of a few drops of fresh blood, and the external parts are extremely sensitive to the touch. These symptoms are almost certain to depend upon the presence of a vascular growth, or growths at the meatus, or quite within the urethra, a lesion that does not exist in men. Whatever the name or nature of these fungosities, whether they are developed from the vascular papillæ which abound in that locality, or from an hypertrophy of the urethral mucous membrane, if we consider them as hemorrhoids of the urethra (Richet), or as tuberculous (Terrillon), or glandular, or as papilloma (Verneuil), with a proneness to degenerate into epithelioma, their clinical history is extremely interesting and suggestive. They represent a form of urinary suffering that has no connection with urethritis, specific or non-specific, neither with any form of cystitis. And not only do they give rise to the symptoms just named, but if they are large enough, or numerous enough, they may block the urethra like a stone and so cause an absolute retention of the urine.

2. *The Mechanical Causes.*—Of the external causes of vesical irritation, the most common in those who have not borne children is the forward inclination of the fundus uteri, a condition that is entailed upon the patient from her childhood, and which is often very much aggravated by a fruitless marriage, habitual constipation, tight lacing, and dancing. Other forms of uterine displacement that excite the same symptoms (which symptoms are neither peculiar,

special nor characteristic in their therapeutical significance) are prolapsus, retro-version, the forward pressure of the womb by retro-uterine growths, effusion, hemocele, extra-uterine foetation, and the dragging of the bladder upward by the gravid uterus, fibromata, ovarian cysts, etc.

One of the lessons of abdominal surgery is that displacements of the ovaries and of the Fallopian tubes in the direction of the bladder, and their adhesion thereto are by no means infrequent, an abnormal condition that may serve to explain the marked aggravation of the urinary troubles with the return of the menses. The possible adhesion of the bladder to all sorts of pelvic and abdominal tumors makes vesical irritation and suffering a very common symptom in their clinical history.

The pressure from the gravid uterus directly after conception in many cases, and almost always in the later months of pregnancy, greatly disturbs the function of the bladder, and may occasion more suffering than any other contingent of gestation. As Playfair has shown, it is especially when the pregnant uterus lies in an oblique position that this result is likely to happen, and his happy expedient of correcting the malposition of the foetus by external manipulation for the relief of suffering when a woman at the sixth month finds it necessary to urinate very often, and suffers greatly from dysuria, is one of our simplest and most efficient resources. For in such cases, whenever the long axis of the child is made to correspond with the long axis of the womb, this distressing affection will be relieved.

There are cases of pregnancy in which the pressure of the growing uterus upon one or both of the ureters induces an irritable condition of the bladder partly through the direct mechanical injury of a portion of the urinary apparatus, but more decidedly, perhaps, by rendering the urine both scanty and albuminous.

And it is the rule in advanced cases of cancer involving the body of the womb that a like pressure upon one or both the ureters, because of the increased size of the organ, or from infiltration of the peri-uterine tissues, shall



obstruct the flow to the bladder and occasion vesical suffering. Renal inadequacy from this cause is the rule and not the exception, and in most cases, so long as the secretion is not wholly suppressed, it is accompanied by an increased desire to urinate, with a more or less constant irritation of the bladder. I have been consulted in quite a number of cases of uterine carcinoma in which the real lesion had been overlooked, and the clinical emphasis exclusively placed upon the symptoms connected with the bladder.

One of the most troublesome sources of mechanical irritation of the bladder is the pressure induced by the small-sized fibroids that are sometimes seated between it and the uterus, being an outgrowth from the latter organ. In this locality they are rarely larger than an English walnut, or a lime, but they are so hard that they press like a stone against the bladder, partially inverting it, narrowing its capacity, and nagging it whenever the patient is in an upright position, when the bowels are moved, or when, in lying, she turns from one side to the other.

In fashionable young women the habit of tight-lacing and of wearing clothes suspended from the waist, and not from the shoulders, is a very common cause of these bladder troubles. Many of them are treated locally with the result of increasing the mischief, and many more are being dosed *secundum artem* with no better effect.

Few women realize the importance of attending promptly to the natural inclination to empty the bladder. Failure in this regard, whatever the motive or the excuse, is a fertile source of urinary troubles in young women especially. Like so many other kinds of suffering in women this habit often dates from life in the boarding school. Until within a very few years, and even now, the conveniences for relieving this necessity in public places, while traveling, and in social life, are not what they should be, and the consequences are inevitable. The native modesty of our American women, which will not suffer them to attend to this matter in so indifferent and indelicate a way

as is common on the continent of Europe, multiplies these cases here at home and calls for relief.

3. *The Reflex Causes.*—There is a nervous cause of vesical irritability in women that should not be overlooked, *viz.*: the effect product upon the bladder by being in the company of disagreeable and uncongenial people. It often happens that some social, personal, or domestic antagonism is the root of the difficulty, especially if the feeling has to be suppressed and can find vent in no other way. Other general nervous causes of urinary distress and suffering are the jar and the trembling, vibratory motion experienced while riding in a railway coach or a street car; forced and unseasonable intercourse; and the peculiar irritability that sometimes precedes the menstrual flow. This anomalous form of dysuria is common in those who are very impressible and who are of a highly sensitive organization. In such patients the bladder centres become involved in the general systemic disturbance, and the urinary derangement follows just as the hysterical nerve-storm ends in diuresis.

Functional derangements of the digestive organs sometimes occasion an extreme irritability of the bladder by changing the character of the urine, but more often, perhaps, through the reflex sympathy that exists between them. The kind of local disorders under review may indirectly depend upon gastric or intestinal indigestion, hepatic torpor, constipation, or copræmia.

No one who has treated dysentery and observed the frequency with which the anal and vesical sphincters are sympathetically affected, but is satisfied of their morbid relationship, and of the possibility of the urinary organs being the seat of reflex disorders that depend upon some local trouble within the rectum. It has long been known that an almost incessant call to urinate might primarily depend upon inflammation, ulceration, spasm or constriction of the rectum, or upon hæmorrhoids, and that the way to cure it was to address our efforts to the removal of the remote cause.

The divulsion of the anal sphincter by the expansion of the rectal speculum has been a recognized resource for the cure of this difficulty since the time of Recamier; and the simpler and better method of stretching the sphincter by the thumbs, as proposed twenty years ago by Tilt for the relief of vaginismus, has long been practiced for the relief of reflex bladder troubles in women. Whether it is done intentionally or incidentally the effect of paralyzing the irritable sphincter in suitable cases is always the same, but as in resorting to the hackneyed expedient of dilating the cervix uteri for the relief of dysmenorrhœa, the operation may need to be repeated. Thoroughly to stretch the sphincter ani, and then to evert the lower extremity of the bowel, as was advised by Dr. Storer in 1872, will disclose the mucous lesion within the rectum, if there is one, and dispose of the spasmodic contraction which is the indirect source of mischief within the bladder. But this expedient is not successful in all cases indiscriminately. If the vesical trouble is really inflammatory, or post-inflammatory, it is likely to be harmful; while, as we all know, the "irritable neurotic" who suffers, and who may have suffered for a long time with an anomalous affection of the bladder may sometimes be greatly relieved by it.

In other cases it is sufficient to practice the forcible dilatation of the urethra and of the neck of the bladder. Here the paralysis of the peripheral filaments that are most directly concerned in the local spasm and suffering puts an end to the incident symptoms, and if the case is a slight one there may be no relapse. But if the reflex centre, wherever it may be located, is seriously involved, the relief will be only temporary, and a resort must be had to other and additional means of cure.

4. *The Constitutional Causes* include those depraved and debilitated conditions of the general system in which there is a low vitality and an increased tendency to nervous affections generally. Anæmia is a frequent cause of this class of troubles, and whether it follows menorrhagia, too rapid

childbearing, or being overworked and underfed, as so many of our women are, the result is the same.

Every physician who is experienced in this line of practice and who has kept his clinical eyes open has noted the proneness in some of these patients to the slighter forms of bladder trouble whenever they were chilled. In them the merest trifle in the way of a rigor will prompt the desire to urinate, and if they are not warmly dressed in bad weather especially, the urinary mischief will easily be perpetuated.

This hint should be enough to suggest that malarial conditions may beget urinary mischief, and will therefore explain the occurrence of obscure cases of the kind in paludal districts, and in those who have once had the ague. I could cite a number of cases that I have easily and readily cured by bearing this simple fact in mind, and by prescribing upon a purely clinical indication.

Similar troubles of the urinary organs in women are associated with tuberculosis, especially if it has attacked the peritoneum or any of the organs within the pelvis, or if, in an obscure way, it is associated with either of the forms of diabetes.

The puerperal dyscrasia, the effect of repercussed eruptions, and the hysterical diathesis are also among the constitutional causes of these anomalous affections that are in no way associated with organic change or with the inflammatory process.

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## Clinical Society Transactions.

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H. N. LYON, M. D., SECRETARY.

AUGUST MEETING, 1889.

The regular monthly meeting of the Clinical Society was held at the Grand Pacific Hotel, Saturday evening, August 31. Although many of the resident members had not returned from their vacation, the number present was twenty-five. The President, Dr. E. S. Bailey, occupied the chair, and, a few matters of routine business being disposed of, the Society heard the

### *REPORT OF THE BUREAU OF SKIN AND VENEREAL DISEASES.*

DR. T. S. HOYNE, CHAIRMAN.

THE SKIN SYMPTOMS OF TELLURIUM.—By T. S. HOYNE, M. D.—In the treatment of the various forms of eczema and herpes there is one remedy that is not often thought of, although a drug with well-marked skin symptoms. I refer to Tellurium—a remedy which presents cutaneous symptoms which strongly remind us of that most common and often obstinate affection, eczema. According to the provers of this drug the eruption usually commences in the form of papules of a very bright red color, but soon becomes converted into a vesicular patch. The eruption is attended by very severe itching, both day and night, but is much worse after going to bed.

Although the papules appear on both sides of the body, they are, as a rule, more numerous upon the left side, and in some instances are entirely confined to that side of the body. The parts affected are the upper and lower extremities, the head and face, the left ear, the hands and feet, but rarely are they found upon the chest and abdomen. The eruption is prone to last a long time.

In addition to a papular eruption, some of the provers noticed a breaking out of vesicles upon an inflamed base, which dried down into thin scales. One peculiarity of the eruption upon the extremities is, it begins first on the outside of the calves and then on the inside of the forearms above the wrist, and then spreads from these points.

One is reminded somewhat of Apis, by the character of the pain sometimes experienced, namely, little stinging prickings in various parts of the skin. The location of the vesicles about the ears suggests Graphites to us, as does also the constipation, which is a well-marked symptom of Tellurium.

One of the symptoms, aside from the itching, puts us in mind of syphilis; small red points on the left hand, shining through the skin, which sometimes itch; itching also of the feet.

In one of the provers of Tellurium a little spot of herpes circinatus made its appearance upon the forehead, was attended by troublesome itching, which changed into smarting when rubbed.

The patient for whom Tellurium is applicable is very quiet and neglectful of his business; he takes cold in the head easily, even in fresh clear air. Discharges from the ear, or the eruption, has a fishy or at least a disagreeable odor. The upper portion of the spine is somewhat sensitive to the touch. The itching of the skin is worse in cold weather.

In this connection I will mention several cases where the remedy has proved very serviceable.

*Case 1.*—An elderly lady reported that she had lately been much annoyed by a weeping eruption about the left ear and upper portion of the neck, which was attended by very severe itching day and night, but was always much worse at night, greatly disturbing her rest. There was a very disagreeable odor, at times, from the parts affected, but it was not always noticeable. Her general health, she stated, was quite good, except that the bowels were usually constipated. At times there was stinging itching in various parts of the skin like flea bites. Tellurium 8, soon relieved her.

*Case 2.* A boy of five or six years of age came to the Hahnemann dispensary some four weeks ago with eczema capitis and faciei. There were also a few patches on the inside of the forearms, but of very small size. The mother stated that it had lasted a number of weeks, and that it had resisted all sorts of treatment—in fact, thus far nothing had benefited him. She had cut off his hair as carefully as possible, so that she could get at the scalp and scrub it. In fact, she had scrubbed it entirely too much, and had thereby greatly aggravated the disease. The eruption, which covered the entire scalp and part of the face, had a decided fishy odor. The boy slept pretty well at night, but was constantly digging at his head in bed, causing it to bleed in places. Tellurium, 30, was ordered four times a day. At the end of the first week the improvement was visible to every member of the sub-clinic class. At the end of the second week, the last time I saw him, the scalp was clearing up nicely as well as rapidly.

*Case 3.* The last case I shall mention was that of a lady aged 30, or thereabouts, who reported that she had had eczema ever since childhood. She had never been entirely free from the disease since she could remember. The eruption had always been located upon the head, face or neck, sometimes upon all these parts at once, but usually was confined to the head and face. Seldom had any other portion of the body been affected. It was always much worse in the winter, particularly the annoying feature of the disease—the itching. Although the disease did not leave her during the summer it was more bearable, as the itching was only troublesome after going to bed. Various local applications had given her temporary relief, as had also a number of homœopathic remedies which she had taken, but nothing seemed to cure it—it always returned as bad as ever after a temporary relief. Graphites, she thought, had done her more good than any other remedy, hence I gave her this drug in the highest potency and afterward as low as the 6th during several weeks, without any decided or permanent benefit. There would be a little improvement at times and then a relapse. Finally, I put her on *Tell.* 8, and the improvement was noticeable at once. At the end of six weeks not a trace was left of the disease, and it has thus far never returned.

It will be found true, I think, that tellurium always follows well after graphites. At least that is my experience in quite a number of cases.

Dr. Hoyne also gave the details of a case of psoriasis complicated with ringworm.

DISCUSSION.—DR. LEAVITT: Was the eruption in the case last reported the same throughout?

DR. HOYNE: No; some were the characteristic patches of psoriasis, while others showed the island of healthy skin, characteristic of ringworm. In other respects they were similar.

DR. LUDLAM: Was there any menstrual irregularity, and how long had her trouble existed?

DR. HOYNE: Not that I learned of. Aside from the eruption she appeared perfectly well. She had been in poor health for many years.

MRS. DR. BACON asked for suggestions for the treatment of the following case: A woman now over sixty years of age has been troubled for more than a year with an eruption, which starting on the external genitals has extended upwards on the abdomen to the level of the umbilicus. The skin over the affected area is moist and fissured. In spots it is quite raw. The itching is much worse at night. In other respects she appears perfectly well.

DR. HOYNE: The case is either one of eczema or intertrigo. Intertrigo occurs in the folds of the skin, and the discharge, which is watery, does not stiffen the linen. I should call that a case of intertrigo. Lycopodium is one of the best remedies. It can be used locally in the powder as well as administered internally. A little corn starch dusted over the part will allay much of the irritation.

DR. BACON: Is vaseline or the cerates objectionable locally?

DR. HOYNE: Yes. The skin is already too soft and they would serve to soften it still more. It should be kept dry by the use of corn starch. Cases of intertrigo of the nates are not uncommon in which nothing is necessary in the line of treatment further than the application of a pad of borated cotton to keep the surface from chafing.

DR. LEAVITT. I have usually had the best results from the use of arsenicum.



DR. HOYNE: Arsenic is very good, especially when the discharge is acrid.

DR. BELLE L. REYNOLDS asked for a discussion of the following case: A child aet. three years has a pustular eruption that first appeared on the eyelids but soon disappeared from there under the administration of *Hepar 30*, but only to reappear on the top of the head, which is now covered with this eruption. Did the hepar drive the eruption from the eyes and will it act beneficially if continued?

DR. HOYNE: That is probably a case of pustular eczema and the prescription is a good one.

DR. REYNOLDS: Would you advise any local application?

DR. HOYNE: No. I should continue the hepar. If the eruption becomes offensive tellurium would be better.

The following case was reported by Dr. C. S. MACK:—  
*Case:* The patient, a young man, on awaking yesterday morning discovered that one eyelid was puffed up, and somewhat œdematous. Later the other eyelid also became swollen. I gave *arsenicum*. In the afternoon both eyes and the bridge of the nose were swollen and red. The cheeks were red. The prepuce was red and œdematous, almost approaching a condition of phymosis. There were no other symptoms and he has had no fever, no itching or burning and no eruption.

DR. HOYNE: It is a light attack of rhus poisoning. The plant grows abundantly in that locality. Several years ago Dr. Andrews had a number of cases in the same vicinity.

DR. LUDLAM: What is the most effectual antidote for the effects of the poison ivy?

DR. HOYNE: There is no antidote. Apis is most generally applicable. I have had good results from hepar when there was ulceration of the feet.

DR. J. P. COBB: I had a case a few days ago which started from a small spot on the forehead resembling a mosquito bite. The right eye became puffy in a short time,

and the next morning the left one was swollen. Each eye remained closed for about twenty-four hours.

DR. LYON: As a local application in these cases, as well as in urticaria, I have derived marked benefit from the use of fluid cosmoline. I use it either alone or in combination with about two grains of carbolic acid to the ounce. In the cases in which I have used it there has been an immediate relief from the burning and itching. After five or six hours its effect wears off, and more of the cosmoline must be applied. The second application is usually sufficient. The ulcers of the feet in rhus poisoning heal readily under this application.

DR. A. K. CRAWFORD: I agree with Dr. Lyon as to the efficacy of carbolic acid in these cases. I have used a prescription composed of carbolic acid, sub-nitrate of bismuth, glycerine and water with excellent results. I have never seen any unpleasant results from its use, while the most severe case will yield to it in a short time. I do not remember the exact proportions, but there is about half an ounce of bismuth and one dram of carbolic acid to the pint.

DR. W. P. MACCRACKEN: I used recently as an application in a case of rhus poisoning, which started in the ear and was accompanied by much swelling, a mixture of the tinctures of aconite, hamamelis and calendula. The swelling disappeared in twenty-four hours.

DR. E. C. READ reported the following case: I was called about eighteen months ago to see a girl *æt.* 13, who was suffering from a severe pain in the left side. On examination I pronounced it a case of enlargement of the spleen. The remedies given relieved the pain, and I lost sight of the case until a short time ago. The pain had then returned, and in addition there was dropsy of the abdomen. On the left side of the abdomen in the region of the colon is an enlargement which has the shape of a saucer turned bottom up. There has been no fever, and the pulse is regular and of normal frequency. It is, however, slightly wiry. The dropsy has now almost disappeared, but the

tumor is increasing in size. The bowels are regular and normal. She is a spoiled child, and her mother insists on her eating almost constantly. The appetite is excessive. The stomach is irritable. There is no vomiting, but a feeling of goneness if she does not eat immediately on experiencing the desire for food. She sleeps well. I have now succeeded in limiting her to three meals a day. Pieces of tissue are being passed with the stools, some of which were submitted to Dr. Bailey for microscopical examination.

DR. LUDLAM inquired if the menses had been established.

DR. READ: Not yet.

DR. LEAVITT: Is there any pain or enlargement on the right side?

DR. READ: No; it is situated on the left side, barely reaching to the right of the median line.

DR. LUDLAM: Is there any anæmia?

DR. READ: No.

DR. BAILEY: The exfoliated tissue seems to be mucous membrane, and does not have the appearance of coming from any glandular body. I have not been able to determine the origin of the pigment observed in some of the pieces. The suspicion of malignancy which is suggested by the symptoms is not confirmed by the microscopical examination; neither would a malignant disease be liable to occur in the glands of a girl of this age.

DR. READ: There has been no hemorrhage, but there is a slight bloody discharge from the mouth in the morning.

DR. LUDLAM: It is probably a case of inflammation and partial obstruction of the colon. I would empty the bowels very thoroughly, give nitric acid, and then wait for the establishment of puberty. The dropsy would not have disappeared spontaneously if the enlargement had been due to a malignant disease.

DR. HOYNE: I have seen similar cases in which the trouble was due to tape worm.

DR. LEAVITT: Is the tumor nodular or smooth?

DR. READ: Perfectly regular.

VOLUNTEER PAPERS.—I. TWO REMARKABLE CLINICAL OBSERVATIONS.—BY DR. H. P. HOLMES.—Clinical experiences may be considered remarkable when they answer to three conditions: *First*, when there is nothing of a similar nature within the experience of the writer or observer. *Second*, when no such clinical experience has been met with by the observer's professional friends. *Third*, when there is nothing in the ordinary text-books regarding such cases. I have recently met with two such cases, and will briefly report them for the purpose of gaining light upon them.

*Case 1.*—The first of these is that of a babe with two ani. Born last August under my administration, I noticed nothing abnormal at the time. Some months later I was informed by a relative of the mother that the child had two rectal openings, and that the mother had not thought it necessary to inform me of it, as she did not know but such a condition was all right in babies. There had been regular passages through both openings, sometimes occurring in one at a time, and again in both at once. The supernumerary anus was situated in the median line, about an inch and a third above the natural orifice. At the end of six months the extra orifice had closed spontaneously, and there has since been no trouble. It would seem that this child came into the world well fitted for the work of the "orificial" surgeon; for while one rectum might be undergoing repairs the other could still keep up its regular attendance upon the calls of nature. However, Nature has seen fit to modify her plans, and has thus removed a very fine field of possibilities by healing up the unnecessary anus. To-day nothing remains of the former opening but a small dimple.

*Case 2.*—The second case which I have to report is one of hydruria. The patient is one of the incurables of the Elgin Insane Asylum, now remaining at the home of her sister. Being called recently to treat this woman for a Colles' fracture, I was told of her abnormal thirst and consequent enormous discharge of urine. She complained of heat and burning throughout the abdomen, which evidently caused the thirst. She said she must drink the water "to wash the sin away," and therefore drank daily twelve quarts of water and passed a like quantity. Suspecting a case of

diabetes, I obtained a sample of urine just passed, and took it to the office for examination. It was as colorless as distilled water, odorless and of neutral reaction. I immediately tested with Fehling's solution, as I thought, of course, it was a case of diabetes. There was no reaction to the sugar test. I then took the specific gravity and found it five less than that of distilled water. The test was made with two urinometers, and each of them then tested with distilled water, and both were found to register perfectly. There was no albumen in the urine.

This patient, therefore, passes daily about twelve quarts of urine which has a specific gravity below that of distilled water. This condition has been present for many months, or I would question if it was not a case of uræmic poisoning, and should fear uræmic convulsions to take place at any time. In this case the "urine passed is not urine but *water*," as Dr. P. Jousset says in his clinical lecture on uræmia.\*

I would like to ask if this is a common feature in insane people, and if, under the circumstances, we are likely to meet with uræmic convulsions at any moment? Is it at all likely that treating these symptoms with the indicated remedy will influence the mania? The case is one of quiet melancholia, with loss of memory of all that happened up to the time the insanity was observed. She seems not to remember her own family, husband or children. Is quiet and gentle, and assists quite a little in the household duties, and shows quite a fondness for little children.

DISCUSSION.—DR. LYON : I would inquire if Dr. Holmes has verified the instruments that he used in determining the specific gravity of the urine in the case which he presents? Urinometers are graduated for two temperatures—either 60° or 70° F., and to secure an accurate reading the urine must be brought to the temperature for which the instrument was graduated. If the doctor's urinometer is of the ordinary pattern, which is graduated for a temperature of 60°, the apparent specific gravity would be about 2.40 less than the actual in such warm weather as we have had for the last week. The urine not unfrequently falls as low as 1.002 and occasionally goes lower as the result of nervous

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\* See *Medical Advance*, November, 1887.

forces, but none of the fluids of the body, whether normal or abnormal can have a specific gravity less than that of water.

DR. LUDLAM referred the members to the report of a case of diabetes insipidus furnished to this Society by Dr. J. Ulrich, of this city, and published in *THE CLINIQUE*, 1881, Vol. II, page 239. In that case the woman, who was eight months pregnant, drunk thirty-six quarts of water daily. The clinical relation of this form of polyuria to tuberculosis is established, but I am not aware that it is concerned in the history of insanity.

2. IS CHOREA A PRODUCT OF CIVILIZATION AND REFINEMENT? By DR. BELLE L. REYNOLDS.

"The humorous features of the session were continually perceptible to the keen observer. The 'Hahnemannian' Bartlett, with the bravest of faces, in a stenographic report, says: 'Dr. Belle Reynolds, of Chicago, said that chorea must be a product of civilization and refinement. Although she had been in a position in which over two thousand children come under observation annually, who had been subject to all sorts of exposure, and who must have inherited all sorts of diatheses, she had never had a case of chorea.'"—*Medical Current*, July, 1889.

Now that the "humorous" editor of the *Medical Current* has returned to his suburban home, perhaps he may find time to read a few additional facts concerning the absence of chorea in the "Chicago Home for the Friendless," as stated by me in the discussion following the report on Pædology at the American Institute at Minnetonka, June, 1889.

The "Home" is now in its thirty-first year; it is the largest of its kind in the United States. Its object is to give temporary homes to women and children of both sexes (boys under twelve) who have been either through misfortune, neglect, or abuse thrown upon the mercy of the public; but its chief object is the care and protection of neglected and ill-treated children. In their admission there is no distinction regarding nationality, religion, sex or color; they are brought from the gutters, the police stations, and from homes where the father is taken to the Bridewell and the mother to the Poor-house. The most depraved, rescued by the Humane Society, are brought to our doors, and all find admission, save the drunken and those with contagious diseases.

Since I took the medical charge of the Home, now nearly five years, I have succeeded in excluding all children, as well as adults, who gave any indication of a syphilitic taint; but no child is refused admission save for these causes, and should sickness occur after admission they are kept in the Home and cared for.

The average stay of the younger children is three months; but if surrendered to the Home, they become members of the family, and some have been there for several years. The records of the institution show an average of 1,200 children a year for the last fifteen years, and *not a case of chorea except the one mentioned by me in the discussion*, a girl of fourteen who had been returned from a home of so-called charitable people, who compelled her to sleep in an attic infested with rats. A few weeks of quiet, with remedies for her nervous condition, entirely removed all choreic tendency, and she is now employed as a servant in the Home.

There are two schools in the institution, a kindergarten and a graded one; one of the teachers has been in charge eleven years and the other nine, and neither has seen a case of chorea in the Home. We have had almost everything else with which childhood can be afflicted, *but no chorea.*

The editor of the *Current* should remember that these children are the offspring of the phlegmatic German, the improvident Irishman, the stolid Norwegian and Swede, and the unimpressible Jew. The wild American rarely figures amongst them. Very few have ever been inside the schoolroom until they come to the Home, and there has never been with them either mental, moral or physical strain or discipline.

My remarks were made in support of my own experience and observation, that the offspring of the lower classes of all nationalities as seen in the thousands of children in the Home and Hahnemann Hospital clinics, are strangely exempt from this form of nervous affection, and that what is called civilization develops and increases the tendency to chorea, hysteria and other neuroses. Who ever saw a case of neurasthenia or brain-fag in the Bridewell or Poorhouse? On the other hand, whatever affects the nervous system, such as badly directed education, the forcing process of young girls, high living, novel reading, and many inherited weaknesses, will tend toward the development of the nervous disorders. And these are plentiful amongst

the children of the better classes, and fall to us in our private practice.

Even if my statement at the Institute meeting was at variance with the best literature of the subject, and also with the general knowledge of the chief predisposing causes of chorea, it would still be true. I must, therefore, contend that it has a clinical meaning, and is worthy of investigation and of record.

3. UTERINE INVERSION. REDUCTION AND RECOVERY.  
BY DR. L. C. WELLS, OF CAMBRIDGE, O.

Case.—May 19th, 1883, I was called in the night to see Mrs. F., who lived in the country; found her to be a large-framed, flabby German woman, aged about 26 years, with a quite large bronchocele. She was confined to bed, her feet raised and head lowered. She was almost exsanguinated. The history given was as follows:

She was delivered three weeks before of her second child, and had been "wasting" ever since whenever she moved. Between the third and fourth months of both her pregnancies she was threatened with abortion. Her first labor was all right, with the exception of a retained placenta. With the second one she had the same experience, and after the delivery of the child the placenta was found adherent. She said the doctor did not remove it in the same manner, as the first was delivered by introducing the hand, for he pulled upon the cord until it came away. This was the case as it was stated to me. The attending physicians had been sent for, but as yet had not arrived. So we awaited their coming without making an examination.

One of them objected to consulting with me on account of my being a homœopathist. The husband then put in a few emphatic words which the doctor did not relish, and he left the case and the house in short order.

The case was then placed in my hands, and I went to work to make a diagnosis and to do what I could for her relief. She was covered with perspiration, the tongue was coated with a thick, white coat with a brown streak down the middle; the pulse was very rapid, and she vomited at short intervals, with great thirst and high fever. Upon making a digital examination, I found a tumor encircled with the os uteri. The whole case was at once cleared up, but the doctor, whose patient she had been, was a long way on his road home. I at once informed the husband of the



condition, and that she must be relieved at once. With the assistance of the women, who were there to see what the doctors would do, I attempted to reduce the womb by introducing the well-oiled hand, the backs of the fingers pressing against the inverted fundus, and after a very long and persistent effort was successful. When the uterus was restored it contracted on my hand, and forced it through the cervix, and this put an end to the hæmorrhage, and she made a good recovery.

Sometime during the next summer I was called to see this woman again. She was now suffering with metrorrhagia. I found several small polypi hanging from the os uteri, which were removed.

This operation was followed with relief and I did not hear from her again until June 14, '85 when I was called to attend her, in confinement. All went well and after a normal labor she was delivered of a son. She told me she had had her usual "wastings" between the third and fourth month. So I had anticipated trouble with the placenta. We waited about thirty minutes but it did not come, and after thoroughly oiling the hand I passed it up well to the fundus and tore the placenta away and delivered it in very good condition. She made a good recovery without the inversion and the hæmorrhage that accompanied her last labor.

In March, 1887, I was called to attend her in her fourth labor. We waited some time but the pains left her and we went home leaving directions in case labor pains should return and it continued to rain, to call Dr. C. near by but in case of any serious trouble to try to get me word. The next night the pains returned and they called Dr. C., who got along very well until he came to the placenta which was adherent. Mrs. F. and her husband plead for him to remove the same but he thought not and that if they would have patience all would be well. So they waited several hours but at last he was forced to introduce his hand and remove it. She had quite a severe hæmorrhage after the removal of the placenta which continued for some days. By this time the flood in the county had receded and they sent for me. I found her in bed and in the same position as at my first visit in 1883. The foot of the bed was raised, the head lowered and she was "wasting" at every movement. I made a vaginal examination and placed my hand over the fundus uteri. Upon introducing the right index well into the uterus I discovered a firm, hard tumor hanging from the fundus which I removed the next day. She made a rapid recovery

and up to this time has never been troubled any more with uterine hæmorrhages. The lesson taught me by this case was that the fibroid, for such it proved to be, was the cause of the inversion, and more than likely had to do with the adhesion of the placenta in each of her confinements.

4. EPILEPSY, HYSTERIA AND MORPHINOMANIA. EXTRACTS FROM A RECENT CLINICAL LECTURE BY CHARCOT. TRANSLATED BY R. LUDLAM, JR., M. D. (*Concluded from page 301*).

The existence of these hysterogenetic points, even when there are no spontaneous paroxysms, enables me to confirm the diagnosis of hysteria. He says that following the typhoid fever he had such attacks during the daytime as he had not had before. He says they were announced by the feeling as of a bar across the stomach, the rising of a ball into the throat, and the inclination to get away, or to go to bed. During these crises he screamed, and it took two or three persons to hold him. In the night he was tranquil, and in the paroxysms during the day the tongue was not bitten, nor did the urine pass involuntarily. Was this an attack of hysteria?

There is still another argument, which is of a chemical kind; but before adducing it, I must once more pronounce against such an use of the terms epilepsy and hystero-epilepsy as only brings confusion. Remember, therefore, that there is no relation between epilepsy and hysteria; there is no hystero-epilepsy with mixed paroxysms, neither hystero-epilepsy with separate paroxysms. In grand hysteria there is only a semblance of epilepsy.

The epileptic is suddenly seized at about three o'clock in the morning; he cries out, or rather makes a peculiar noise; he becomes rigid; his eyes roll, and there is strabismus in which the eyes are turned upward. This is the tonic, which is followed by the clonic stage; it is then that the epileptic bites his tongue, and passes the urine unconsciously. After a few seconds he snores in a stertorous sleep.

Hystero-epilepsy differs from this. But I will not give you a description of it, if I must give it as coming from a foreigner. I have found my own account of it in a Berlin journal, and, strangely enough, it concerns a soldier under the care of Andre, chief surgeon in Carlsruhe. Remember, that in the German army, as well as in our own, there are those who are hysterical. This soldier wished to be present at the burial of the Duke of Bade, but the regulations

prevented, and the disappointment was the cause of his attacks. The description of these seizures is very complete, the author having even added some instantaneous photographs, taken during different phases of the paroxysms. Here we find a marked aura in the headache, the beatings in the ear and the staring of the eyes, and then a tonic stage followed by a clonic one. Thus far the case resembles epilepsy; but even in this condition if you speak sharply to him you can sometimes arrest the fit, a result that can never be obtained in epilepsy. Besides, he does not bite his tongue, nor pass the urine unconsciously. Another condition soon follows in which he takes various attitudes, a half circle, bowing, etc., and the seizure terminates in passional attitudes and hallucinations. This was a real attack of hystero-epilepsy, which was only epileptic in its form, and the term should be dropped.

I have told you that Messrs. Lepine and Mairret had found an increase of the nutritive waste in the urine after an epileptic seizure. Mr. Gilles de la Tourette has made similar tests in hysteria, and he has obtained such remarkable results as constitute a genuine discovery, if they are only verified. Instead of an increase in the amount of urea and phosphates that are eliminated, he has found a notable decrease from the normal. There are only thirteen grammes of urea instead of eighteen, and the phosphates are 1.60 grammes instead of 2.50. The cases reported are still very few, but if these first researches are confirmed they will furnish an argument that is absolutely certain in favor of what I have for a long time taught, that there is nothing in common between hysteria and epilepsy. These two affections have a rough resemblance, but they are essentially different.

We now come to the third nosological condition presented by our patient. This man has developed an artificial neurosis, morphinomania, which is not the least of his troubles. You well know how easily neurotics acquire the unfortunate habit of taking morphine. The physician gives them one hypodermic injection to allay pain. By a culpable negligence he leaves the syringe in their hands, and they soon learn to use it for themselves five or six times a day, and always at the same hour. In a little while it is absolutely impossible for them to stop this habit without serious consequences. What constitutes morphinomania is not the large dose that is taken but once a day,

but the repetition of these injections at regular intervals several times during the day.

Our patient became a morphinomaniac after an attack of typhoid fever. On account of the hyperæsthesia of the left side, his sister urged him to take morphine injections. He soon had malaise and vomiting, but she encouraged him and he persisted with the use of the hypodermics. When the pains had disappeared he continued them until he says that he took about two grammes of morphine each day. As his health improved, we have reason to believe that the druggist gave him much less, so that as he has told us, thirty centigrammes was sufficient. He took the first injection between 7 and 8 a. m., the second at noon, then at 3, 6 and 9 p. m. At midnight, as the servants had retired, he took twenty grammes of laudanum internally. His daily dose of morphine was about thirty centigrammes.

The period of painlessness that follows the injection of morphine lasts from four to five hours. The patients always so arrange it that the periods are run into one another, and so consequently they appear perfectly tranquil. They soon acquire a dark or grayish tint, and a slight trembling motion, but these cases are difficult of diagnosis. If the period of exemption is allowed to pass without renewing the injection there is an outburst of the series of symptoms which are proper to morphinism : the trembling increases, the oscillations become more marked and numerous with cold sweats and a tendency to a sudden and complete loss of muscular power; they have diarrhœa with five or six successive stools, and it becomes impossible for them to eat or drink. Their disposition is soured and they often become insolent, all of which disappears with a fresh injection of the morphine. Our patient is an absolute morphinomaniac, and this condition added to his epilepsy and his hysteria, is the third and most painful of all his troubles.

What is to be done under such circumstances? Whenever a person is a morphinomaniac it is of no use to think of giving him another remedy; we must first demorphinise him, and for this purpose there are two methods of procedure; either to completely suppress the morphine and allow the patient to be tortured and tormented and to suffer for three or four days, or we may replace the morphine with equal doses of laudanum, and gradually diminish them.

But here we have epilepsy and hysteria; if his morphinomania disappears we still have the two other affections to contend with, and with small chances of success. As yet

I have given him no remedies, but perhaps later we shall try to relieve him. Nevertheless, I do not promise to cure him.

5. SEPTIC FEVERS. By W. H. Schrader, M. D., of Chicago. Owing to a large number of cases of fever, both in the city of Chicago and its important adjunct known as Hyde Park, during the months of July and August, I am prompted to express as briefly as possible, the probable cause, and the manner of treatment adopted in those cases which it has been my province to treat.

The exaggerated and erroneous reports of the press of a typhoid epidemic has caused inquiry among physicians, and instilled fear in the hearts of a trembling public, lest one or the other should become entangled in the meshes of this disease, and hopelessly surrender to its deadening influence.

Notwithstanding we have had to deal with a kind of fever which in many respects resembles typhoid, especially in its onset, there are differentiating features, which render it as separate and distinct as is catarrhal angina and diphtheria. It cannot well be disputed that we were called upon during the months of July and August to treat cases of fever in number unusually large compared to former years, and the cases which at the beginning seemed perplexing, now are more easily understood and refute the idea of an epidemic.

Septic fever like typhoid, comes on gradually, the time of incubation spreading over a period of from one to three weeks; there is during this time continued gastric disturbance, dull headache and a feeling of stiffness in the cervical region as if from a severe cold, belching, and frequent accumulation of gas in the transverse colon, there is a feeling of weakness in the morning on arising, and the patient is reminded that the night has been a restless one—one of frightful dreams.

These symptoms continue for a time, more or less prolonged, when the patient finds himself completely entrapped by the disease.

The period of invasion begins with a severe chill; there is a rise and fall of temperature which corresponds with that of typhoid fever, reaching its maximum perhaps on the second day, and in some instances not until the fourth or fifth day, when the thermometer registers from  $104^{\circ}$  to  $105^{\circ}$  Fahrenheit. At this period, the face of the patient has assumed a scarlet hue, the restlessness and throbbing carotids

forcibly suggest the highly fevered condition of the blood current.

*Case.*—Mr. S., aged 25 years, had been suffering, as above described, for three weeks before he was confined to his bed, the principal symptoms of which he complained being stiffness in the cervical region, and headache which was constant.

At noon on July 29th, he was taken with a severe chill, followed by fever. The temperature rose gradually corresponding to that of typhoid, reaching its height on the evening of the fifth day, when the thermometer registered 105° F. The bowels were constipated, and the patient belched large quantities of gas. During the course of the fever he complained of pressure about the heart, occasioned probably by the upward pressure of the gas, a symptom occasionally met with in dyspepsia. A noteworthy feature in this, as well as other cases, was a lack of abdominal symptoms; there was no tenderness in the ileo-cæcal region, which is present in true typhoid.

*Causes.*—It will be remembered that during the months of July and August the rainfall on several occasions was tremendous. The sewers were inadequate, and the result was that foul gases were backed up through the waste pipes, filling our tenements with an unwholesome occupant. The water freighted with destructive organic matter, went dashing and roaring out into the great lake, from which Chicago and Hyde Park residents are supplied. From this polluted body of water the people unhesitatingly drank and used freely for all household purposes. I do not think it unreasonable to presume that, judging from the large number of cases manifesting themselves shortly after the storm, and their gradual decrease as the water became more wholesome, that the cause may be attributed to the poisonous properties of our drinking water.

*Treatment.*—The initial remedy in this as well as in other conditions, where there is a dry, hot skin, was *Aconite*, given in the second decimal dilution, so as to produce profuse perspiration, after which the patient usually expressed a feeling of relief. This state of well feeling, unfortunately does not last but a short time, and is followed by a repetition of rise and fall of temperature and increased violence of all the symptoms. The patient always passed a very restless night on account of pain in the stomach and transverse colon, usually commencing at 2 o'clock a. m.,

which *colocynth* 2 dil., twenty drops in half glass of water given in teaspoonful doses every fifteen minutes, until four or five doses had been taken, never failed to relieve. The patient craving cold drinks, he was placed upon *Ars. alb.* 2, in tablets, taking one every three hours. The headache and feeling of stiffness in the cervical region, together with chilly sensations, yielded to *Gels.* fifteen drops of the mother tincture in half a glass of water, given in alternation with *China* prepared in the same manner, every hour.

When the temperature had reached its height, which was 105°, the great loss of vital power suggested the necessity of cutting down, and holding, if possible, a tight rein upon it. The remedy used for this purpose was *acetanalid*.

It may seem to many like adopting radical means, but perhaps of two evils, that of allowing the temperature to continue to run high for an indefinite period, and to adopt radical means, the latter seems to me to offer the greater hopes for the patient's recovery.

This remedy should be given with caution, only on a rising temperature, and *not* where it is descending the scale, however high it may be. A five grain powder of acetanalid was given at 4:30 p. m. for two consecutive days, the effect of which was noticeable one hour after its administration, the temperature beginning to drop, and by the following morning it was a noticeable fact that the patient had in reserve a greater amount of nerve force than if the temperature had been allowed to continue at its high mark.

Acetanalid, unlike antipyrin, does not depress the system, when given in small doses, and the action of the intercurrent homœopathic remedy is not interfered with. Never give this remedy on a lowering temperature for fear of reducing the same below the normal, when you will again have a repetition of chills and fever to deal with as in the onset of the fever.

Throughout the course of the fever, and for some time after, constipation was a difficulty hard to overcome. To administer remedies which relieve the bowels, however mild the laxative, is often followed by a debilitating diarrhœa, a condition always to be avoided. The manner adopted in the case under discussion was to give the patient an enema of Castile soap and water every other day.

It is far more desirable to relieve the bowels, giving greater comfort to the patient, by gently evacuating them about as often as above described, than to allow them to continue in their distressing sluggishness. The head symp-

toms usually become lighter, and the pain in the epigastric region is greatly reduced.

With regard to diet, milk was the principal food; it, however, becomes loathsome to the patient after a few days, when chicken broth, mutton broth, or occasionally a cup of Phillips' digestible cocoa may be given, which will be relished by the patient. It has been my experience that, to allow the patient to consume small quantities of food, at short intervals, is far more advantageous than to cut down his rations to nothing, a thing frequently done.

It is my firm belief that patients suffering with a protracted siege of fever, many times become greatly reduced in vitality by reason of total abstinence from food, so that, as the fever subsides they do not rally, because of the greatly reduced condition of the vital powers. This is especially true of long continued cases of typhoid, the patient's rations are shadowy, and he is fed upon large doses of nauseous drugs, which, if only continued long enough, will certainly place him within the grasp of the inevitable destroyer.

6. CASES FROM PRACTICE. BY OSCAR B. HANSEN, M. D., OF COPENHAGEN, DENMARK.—*Case 1.*—GASTRIC ULCER.—Johanne H——, twenty years old, unmarried, had chlorosis three years ago which ceased for a short time, with relapses, but on returning showed itself worse each time. Half a year ago she began to have besides the chlorosis strong, heavy, dull and oppressive pains in the pit of the stomach and back, vomiting after meals, and in the morning she would generally get about a teaspoonful of bright flowing blood in the mouth. She was then treated at the hospital at Frederikssund, her treatment consisting of liquid muriate of iron and iron pills. When I began to treat her the symptoms were as follows: Giddiness, ringing in the ears, asthmatic, burning pains in the pit of the stomach, and along the ribs on both sides toward a point on the back directly opposite the end of the sternum. With the pains there follows nausea, vomiting of food and slime, the egesta often containing light colored blood, and every morning some blood gathers in the mouth. During the fits of pain, which usually commence shortly before noon, and at night between twelve and three o'clock, she has cold hands and feet, and throws her body in all directions. The fits last about an hour, and are followed by debility and fatigue.



Until a year ago the menses were regular, but then ceased. The stools are hard, clustered, and are passed every other day. The sleep and appetite are poor. Emaciation. She is sore to pressure about an inch below the end of the sternum, but only at a single point. She is fair-haired, rather tall, pale and thin. The thoracic organs are normal. The heart-sounds are clear, but low. The symptoms are worse after meals and when she moves about.

Coffee, tea, spices, and sour things were prohibited, but milk was allowed. *Arsenicum alb.* 3, three times a day.

July 1.—The pains in the epigastrium and the back have abated considerably, and the vomiting has ceased. The food begins to agree with her. No blood has gathered in the mouth during the last eight days. The same remedy was directed for morning and evening for a fortnight, and then no medicine for fourteen days.

August 5.—The evacuations are normal. The pains in the pit of the stomach and back returned but once, and then very slightly. The menses have not yet appeared. There is still some debility and fatigue, which diminishes when in the open air. *Pulsatilla* 6, two drops in a teaspoonful of water morning and evening.

September 7.—The menses returned August 23, and lasted one day, the discharge being somewhat pale. She eats and sleeps well. No more pains in the stomach or the back.

September 28.—The menses lasted this time three days and were normal. She is easily tired when walking, but otherwise feels quite well. Her appearance is good, her color is better, and she is getting plump. *China* 2, two drops in a teaspoonful of water morning and evening for a fortnight, and then no more medicine.

October 20.—Discharged cured.

*Case 2.*—POST-SCARLATINAL NEPHRITIS.—A. F.—, three months old, a fortnight ago had a reddish colored eruption all over the body, with desquamation in a small degree, but otherwise has been well. Four days ago a diarrhoea, sour-smelling, yellow and thin, commenced with four stools a day, from which the child has become very much emaciated. The discharges are not very large, and there is no sign of rickets. Takes its nourishment from the bottle very eagerly. The skin is burning hot and dry, and very pale. *Calcareo carb.* 30, three pellets at noon, and *Arsen. alb.* 6, three pellets morning and night. Milk, gruel and salep.

July 21.—Little improvement; the same prescription.

July 25.—Diarrhœa strong; thin, yellowish-white and frequent. Uneasiness and screaming. Stopped the cal-carea carb., but continued the arsenicum with *Veratrum alb.* 3, three globules four times a day.

July 28.—Evacuations more solid, grass green, and often painful discharges. Anasarca swelling of the feet and legs. The urine was gathered on a sponge and found to contain large quantities of albumen. The face is pale and puffy. *Merc. sol.* 6 dilution, three times a day, and *Arsen. alb.* 6, three globules three times a day.

July 31.—No change. *Merc. sol.* 6 trit., three times a day; continued the arsenicum.

August 4.—The urine contains broken tube-casts, with dropsical swellings over the loins and in the face, and the child is seldom wet. *Hepar sulph.* 3 trit., three times a day.

August 8.—The discharge of urine has somewhat increased, but the general anasarca has decreased. Same remedy four times a day.

August 12.—Continual improvement. Two stools that are more solid each day. Same prescription. This child took *Hepar sulph.* for another fortnight, and complete recovery followed. When the treatment ceased the urine was normal and all the swellings had disappeared. It is now a strong and healthy child.

*Case 3. DIPHThERIC INFLAMMATION OF THE THROAT AND CROUP.*—K. S., six years old, came under my care March 25, 1880. The patient, a little girl, has for a couple of days had fever with difficulty of swallowing, heaviness in the head, pains in the neck, a yellowish white discharge from the nose, and no appetite. Pulse 120. The pharynx is red colored with a whitish coating; the soft palate is swollen, drawn forward and œdematous, and there is a bad odor of the breath. The skin is dry and burning hot. *Aconite* 3 and *Apis* 3 alternately every two hours.

March 25, evening.—No change. The same prescription.

March 26.—The coating on the pharynx is spreading. *Apis* 3 and *Merc. cyan.* 12 every two hours alternately.

March 26, evening.—The fever has diminished, and the swelling of the soft palate likewise. There is a little perspiration and less difficulty in swallowing. The coating of the pharynx is falling off at some points, and there is little cough and hoarseness. *Spongia* 3 with *Merc. cyan.*

March 27.—The deposit has diminished considerably, but the general condition is bad enough. Dry hacking cough with hoarseness, little dyspnœa, the face is somewhat pale, not bluish. *Iodium* 2 two drops and *Hepar sulph.* 3 trit. each alternate hour.

March 27, evening.—Is weaker but continues with the *Hepar sulph.* alternately with *Bromium* 2 and inhalations of *Bromium* 1.

March 28.—Considerable improvement in the cough and hoarseness; the expression is better and the color of the face is healthier. There is some appetite. The pharynx is normal. The same prescription.

March 28, evening.—Continued improvement; the same prescription but to be repeated only three times a day. Stopped the inhaler. The cure progressed rapidly and on the third of April the child was dismissed.

*Case 4.*—CHRONIC APHONIA.—Soren L——, twenty-six years old, a carpenter by trade, commenced treatment June 12, 1880. As a child he had had some trouble with the chest, but later had been quite well. Has now had Allopathic treatment for hoarseness for six months, but without effect. He complains of faintness, emaciation, hoarseness, dryness in the throat, a dry fatiguing cough, with sometimes a little white, thick expectoration, and asthma with a feeling as if something was sticking in the throat. He is cold towards evening, but perspires during sleep at night. There are physical signs of pneumonia in the apex of the right lung. *Phosphorus* 6, two drops morning and evening.

June 19.—Worse, on the whole. *Phosphorus* 30, five globules morning and evening.

June 29.—The cough has ceased and the hoarseness is nearly gone. All the other symptoms have diminished. The same prescription to be continued for a fortnight and then stopped.

August 14.—Is completely well, and growing corpulent. Discharged.

April 13, 1881.—For the last fourteen days he has been a little hoarse, but otherwise is quite well. Nothing abnormal is heard in the lungs. Phos. 30, five pills morning and evening for a fortnight.

Feb. 18, 1882.—He has been hoarse for four weeks, but is otherwise well. He says that the hoarseness when it shows itself during the last two years always has been milder

and less fatiguing. Nothing abnormal in the lungs. Phos. 30, five globules night and morning for nine days, and then a pause of four days, and if necessary once more in the same manner. He was quite well in a fortnight.

*Case 5.*—ASCITES.—Anna W., aged four years, came under treatment January 27, 1883. Two years previous I had treated her for a complicated attack of inflammation of the lungs, with a considerable jaundice and enlargement of the liver. There was soreness when pressing over the liver, and later during that illness all the symptoms of meningitis appeared, and diarrhœa commenced. Her temperature during this long illness at most times was very high and the emaciation was so pronounced that I thought of tuberculosis, but she recovered and has been well until this present illness began. For the meningeal symptoms the twelfth dilutions of *Apis* and *Cuprum* were used with success.

The present illness commenced three weeks ago with considerable enlargement of the abdomen, which had always been large and projecting. The parents thought that she was doing well, but on the 22d of January she felt weak and drowsy and two days later she had vomiting with fever and want of appetite. The abdomen continued to enlarge and I was sent for on the 27th. Being ill at the time one of my colleagues visited the patient for me, but found nothing abnormal in the lungs, the heart, the liver or the spleen. The urine showed no abnormal elements. The appetite and sleep were poor; the bowels regular; the discharge of urine frequent but in small quantities, and the color thereof normal

I gave *Apis*, 1, and *Arsenicum*, 2, alternately, but the ascites increased, and the child began to be blue on the tip of the nose and the lips, and asthmatic with a frightened expression of the face. The appetite was poor, and there was a slight diarrhœa with thin and often bloody stools. After five or six days use of the medicine, *Helleborus*, 3, was given instead of the *apis*, alternately with the arsenicum. I did not believe that the *apis* would be of any service, as it generally operates best when the starting point of the dropsy is a serous inflammation, but here the effusion must have depended upon pressure upon the veins somewhere within the abdomen.

The patient grew worse, and on the 22d day of February the circumference of the lower part of the abdomen was

from eight to ten inches above the normal, while emaciation in a considerable degree was visible over other parts of the body. On the neck were felt small, hard, enlarged glands. The discharge of urine was slight, and was repeated only once or twice in twenty-four hours. No appetite, diarrhœa four or five times a day, the stools being of a very light yellow with some slime. The skin was dry and burning, the pulse small and quick, with thirst, a loose cough, and a rough rattling of mucus was heard all over the back. *Iodium*, 2, with *Apocynum can.*, three drops twice a day of each. After three days some improvement, the abdomen began to diminish, she drank a little milk and took some beef-tea and wheat bread.

About the last of March she was suddenly seized with heavy green vomiting, a temperature of 104°, great frequency of the pulse, a death-like stare, deep-set eyes, and thirst. *Aconite*, 3, brought a change in twenty-four hours, and then I resumed the use of *Iodium* and *Apocynum*, which diminished the size of the abdomen and brought copious discharges of urine. The appetite returned, and at the end of May every sign of dropsy had disappeared, and the child is now entirely well.

[TO BE CONTINUED.]

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## Hospital Notes.

### THE CLINIC ON GYNECOLOGICAL SURGERY.

REGULAR SERVICE OF PROF. LUDLAM.

REPORTED BY DR. ANNA C. HARDY.

The following notes were taken from this clinic for Wednesday, August 21, 1889:

LACERATION OF THE CERVIX UTERI AND PERINEUM.—*Case 20524.*—Patient, *æt.* 30, mother of three children, the youngest being three years old, had a history of hard and tedious labors, since the last of which she has been in wretched health. On examination the cervix was shown to have been torn, but not very badly, while the perineum had been severed to the margin of the sphincter. Both operations were advised to be made at one sitting, the cervix to be stitched with the long-lasting catgut of Riverdin, and the perineum closed by Tait's method.

PROCIDENTIA UTERI AND CYSTOCELE.—*Case 20517.*—Mrs. —, *æt.* 60, has had five children, the youngest of which is 21 years old. She passed the climacteric ten years ago, and has suffered since that time with a tumor which lies between the external labia. The class was shown the points in diagnosis; the passage of the sound into the uterus from below, and of the same instrument into the bladder from above; the reduction of the tumor by taxis; a demonstration of the accompanying rectocele by passing the finger through the anus and into the recto-vaginal pouch; and also the torn perineum, which must have resulted from childbirth more than twenty years ago. Colpo-perineorrhaphy, or the narrowing of the vagina and the closure of the perineum by a double operation, was advised as the only possible means of cure.

PELVIC PERITONITIS WITH SALPINGITIS.—*Case 20523.*—Mrs. Z, aged 30, has had three children, the youngest being 14, has lately suffered severely from dysmenorrhœa. She now complains of sharp and unbearable pains which came at the month and for several days confined her to bed, but of which she is a little better now. Local examination reveals the uterus

badly prolapsed and at the left side of the cervix there is a swelling that is as large as an orange. This tumor is excessively tender to the touch and its outline is readily made out by conjoined manipulation. She lies best on the affected side, the general abdomen is painful and she has much nausea. There has been no discharge of pus from any source. The pulse is that of peritonitis.

The clinical points made were: the significance of post-*puerperal dysmenorrhœa*, especially in those who did not have painful menstruation prior to conception; the rapid development of a special tumor lateral to the uterus, with coincident peritonitis and exquisite suffering, but without the signs of collapse that accompany *hæmatocele*; and the fact that tubal obstruction at the month may determine a menstrual struggle and a localized peritonitis with effusion. *Colocynth*, 3, every two hours, and a warm sitz-bath morning and evening. While she is improving, and especially during the dog days, neither tapping by the vagina nor laparotomy should be resorted to.

ACUTE RETROFLEXION.—*Case 20525*.—F, unmarried, æt. 50, has much pain in the top of the head and the vertex, which her sister says at times makes her really insane. There is a hard body which lies against the right side of the rectum and which is immovable. The sound is passed with difficulty around the angle formed by the flexure of the uterus. The bowels are not constipated.

This is a uterine headache, and in styling the displacement "acute" you are to remember that we do so because the angle that is made by the bending of the womb upon itself is sharp, and not because the deviation has come on suddenly, or because it is attended by symptoms that are inflammatory or violent. We are not always warranted in forcing a misplaced uterus with concomitant lesions into position at the first interview, so she must come again. *Nux vomica* 3 four times a day.

SCIRRHUS OF THE CERVIX UTERI.—*Case 20525*.—This woman was 49 years old and had had five children and two abortions. She complained of pain in the back and the stomach, loss of appetite, vertigo, exhaustion, sleeplessness and an offensive leucorrhœa. Examination showed the uterine body and the cervix to be shrunken and atrophied. Prof. L. called the attention of the class to the peculiar condition of the lips of the os-uteri which to the touch resembled that of the tips of the fingers of one hand when they are all closed to-

gether. This was formerly regarded as an almost certain sign of scirrhus of the neck of the womb, but now we know that its occurrence is explained by stellate lacerations of the cervix resulting from childbirth. It may indeed happen that these apparently nodular bodies are due to cancerous infiltration, but cervical scirrhus is the rarest form of uterine carcinoma.

CHRONIC VULVO-VAGINITIS.—*Case 20510.*—Mrs. —, æt. 39, came to this clinic July 3. She had been married six years, but had had no children. She reported having long been a sufferer from “sciatic rheumatism;” had a great deal of pelvic pain, an excoriating leucorrhœa, frequent urination, and excessive vaginal pain and tenderness. On examination the vulva and the vagina were found to be badly inflamed, hot, dry and very sensitive. Although there were no signs of eczema, or of any vesicular eruption upon the vulva, the violet shade of the inflamed surface and the rheumatic complication had furnished good clinical indications for *Rhus tox.*, 3, which she had taken with the most marked benefit. The local use of a hydrastus solution containing a few drops of listerine had also been very grateful. She has not been so well in six years.

CARCINOMA UTERI.—*Case 20521.*—This patient, æt. 46, has had one child, now 23 years old. She entered a fortnight since. She had been irregular, had skipped the menstrual period for some months, and supposed that it would not recur, when, in consequence of straining at stool, she had a sudden and excessive flow. Six weeks later another hæmorrhage was brought on by reaching her arms over her head. She first took *Crocus*, 3, and afterward *China*, 3. To-day she reports that last week she brought it on again by using her arms to put up a clothes-line. At each visit a local examination has been deferred because of the continuance of the flow. *Trillin*, 3.

The occurrence of an unusual and unlooked for hæmorrhage under such circumstances and at such an age is strong presumptive evidence of cancer, and yet we should not render a positive opinion without a careful physical examination of the vaginal cervix, and perhaps also of the uterine cavity.



## Clinical Reviews.

A LABORATORY GUIDE IN URINALYSIS AND TOXICOLOGY.—  
By R. A. WITTHAUS, M. D., Professor of Chemistry and  
Physics in the University of New York. *Second edition.*  
Wm. Wood & Co., 1889.

If ignorance of pathology was the lawful mother of devotion to therapeutics, there would be no need for books of this kind. As it is not, in the hands of the all-round physician, this Guide will be very handy and helpful.

ATLAS OF VENEREAL AND SKIN DISEASES. Comprising original illustrations and selections from the plates of Kaposi, Hutchinson, Neumann, Ricord, Vidal, etc.; with original text by PRINCE A. MORROW, M. D., etc., etc. Wm. Wood & Co., New York. *Fasciculi* 13, 14 and 15.

These numbers close this remarkable publication, which is a library in itself, with typical illustrations that in point of fidelity and clinical interest excel anything of the kind from any other source. The text is crisp and clear, and gives the essential facts relating to the symptoms, etiology, diagnosis and treatment of these troublesome and intractable affections. Where the proper diagnosis is half the cure, as it often is in this class of cases, and especially where one is obliged to treat them without having had a thorough clinical drill, or a large experience of his own, such a work will be a friend in need, and, if rightly used, will soon put many times its price into the pocket of the doctor who has bought it and who keeps it within easy reach.

A HAND-BOOK OF MATERIA MEDICA AND HOMŒOPATHIC THERAPEUTICS. By TIMOTHY FIELD ALLEN, M. D., LL. D., Professor of Materia Medica and Therapeutics in the Homœopathic Medical College of New York, etc., etc.

Philadelphia: F. E. Boericke, Hahnemann Publishing House. 1889. Quarto, pp. 1165.

Pascal apologized for the length of one of his celebrated letters by saying that he did not have time to write a shorter one. Some years ago Prof. Allen did us the service to gather the grain and the straw from the whole field of our materia medica, and to publish what he thought would be most useful in ten large volumes, with a supplementary stack in the shape of a Symptom Register. The undertaking was stupendous, and involved an outlay which no feeble-footed enthusiast would have dared to venture. The work was issued in excellent form by his enterprising publishers, and gratefully received by the profession. That it has served a very useful purpose none of our readers will doubt. That it was too big and bulky for general use; that it included a good deal of chaff and a lot of weeds, as was unavoidable, and that many of its pages gave evidence of hasty preparation, is conceded by those who are most familiar with the work and most friendly to its talented author.

But in this Hand-book there is abundant proof that Dr. Allen has now taken the requisite time and pains to write us a shorter letter. Not only has he excluded several questionable provings, to which his previous publication gave an unmerited letter of credit; he has also winnowed out whole cart-loads of worthless matter, and, more than all, has salted the production with such CLINICAL hints and paragraphs as will give it a practical relation to the needs of the doctor at the bedside. Whether in every case what has been retained and included is fair, equal and adequate we cannot presume to determine, but we can say that we are decidedly in favor of this work in its present available form.

## Miscellaneous Items.

The Winter Session in the "Old Hahnemann," of Chicago, will open with an Address by the President, Dr. D. S. Smith, and an Introductory Lecture by Prof. Crawford on Tuesday evening, September 17, to be followed by the Annual Reunion and Reception at the Hospital.—There is a lot of students on deck already.—The Bureau of Obstetrics, Prof. Leavitt, Chairman, will report at the next meeting of the Clinical Society.—Dr. W. H. Burt has removed to his new and beautiful residence, 714 W. Monroe street.—Dr. H. P. Holmes will change his location from Sycamore, Ill., to our charming suburb, Oak Park.—Prof. Gee has returned from Colorado with improved health.—We are pained to note the recent death of Judge Vilas, brother of our colleague, Prof. Vilas, and of Col. Vilas, late of the cabinet at Washington.—Prof. Hoyne's Address before the Western Academy was in his best vein, and was very well received; while Bro. Laning gave them a chapter on the "Totality of the Symptoms."—The hospital has been thoroughly cleansed and renovated under the auspices of the celebrated artist, M. Toney.—*Punch* says that in Vienna the doctors *always* make a point of verifying their diagnosis by an autopsy.—Dr. Bramwell's *Studies in Clinical Medicine* in serial form are very popular.—Sample copies of this issue of THE CLINIQUE will be sent to many whose names we would be glad to have on our subscription list.—The Chicago *Medical Journal and Examiner* has suspended publication.—Dr. J. H. Rauch, the indefatigable Secretary of the Illinois State Board of Health, has returned safely from a sanitary mission to the chief cities of Europe.—We must decline publishing the notes of cases sent by Dr. X., because they are too full of his "squirmishes" with the neighboring physicians.

# THE CLINIQUE.

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Vol. X.]

CHICAGO, OCTOBER 15, 1889.

[No. 10.

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## Original Lectures.

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A CLINICAL LECTURE DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, BY W. J. HAWKES, M. D. PROF. OF MATERIA MEDICA, THERAPEUTICS AND CLINICAL MEDICINE.

The first case presenting itself before us this morning for our clinical aid is a woman 48 years of age, suffering from what is known as the climacteric period. Although this "change of life" is a natural process, and should be attended by no morbid symptoms, nearly all women suffer more or less at this time. It is unreasonable to suppose that nature intended that any of the regular functions of life should be attended with so much suffering.

There are four periods in a woman's life during which many abnormal conditions develop themselves; first we have the period of dentition. Nearly every child suffers more or less during the necessary development of the teeth; it is not natural, and it was not intended that this should be the case. The child teething should suffer no more than the puppy or kitten with which it plays; nor would it, had the ancestors of the child lived as perfectly natural a life as did the ancestors of its four-footed playmates. Nature is not to be held responsible for the cholera infantum, hydrocephalus, tubercular meningitis, spasms, and the thousand-and-one ills suffered by teething children.

Next comes the period of puberty; the girl developing into womanhood. During this natural change a vast number of ills is developed—chlorosis, dysmenorrhœa, anæmia, and other grave diseases, which may last the patient

a lifetime, and render her life to a greater or less extent miserable. None of these are to be attributed to nature.

Third, is the period of pregnancy. Few women pass through gestation without suffering from many and varied distressing ailments. Nausea is one of the most common, persistent and annoying, and oftentimes distresses the patient during the whole nine months of gestation. A dislike for her husband and her best friends is a not uncommon experience of the pregnant woman. This, the most important function of nature's highest creation, woman, more than all others seems to develop her latent disease tendencies. It would seem especially unreasonable to suppose that an All Wise Creator would cause the performance of the highest function of womanhood to be attended with the distressing symptoms before indicated, during the whole or the greater portion of the period of gestation.

Again, as in the case of the person before us to-day, the natural change when menstruation ceases is nearly always attended with distressing symptoms, oftentimes insanity. "The change of life" is getting to be regarded by women as a period to be dreaded, and during which all sorts of painful experiences are to be expected. This is all wrong. The climacteric period should be passed through without conscious suffering on the part of the woman.

All abnormal symptoms not traceable to unhygienic modes of living, indiscretions of diet, etc., on the part of the sufferer are attributable to constitutional predisposing causes either acquired or inherited by the individual. These latent disease tendencies have been developed during these changes. It is not true, as we have frequently heard asserted, on what should have been good authority, that any or all of these morbid symptoms belong to these varied changes, are natural, and that consequently, nothing can be done for their relief by therapeutics. On the contrary, I believe that nearly all of these distressing symptoms can be relieved by proper hygienic living, and the carefully selected homœopathic remedy. And I believe further, that no better opportunity can be offered the homœopathic physicians for eradicating in whole or in part these predisposing causes.

The case before us is a woman 48 years of age, who is passing through the change of life—the climacteric period. While this change should occur, as I stated before, without morbid symptoms, almost without consciousness on the part of the patient, this woman has suffered all sorts of

unpleasant experiences for two years past. In her present condition we find that she is extremely suspicious, which she says is unnatural in her. She distrusts her friends in whom formerly she confided. She cannot tell why, but she distrusts them; her sleep at night is restless, frequently waking and always feeling worse after waking than before she went to sleep. This is the case no matter how long or how short the nap. This latter is a symptom which is well worthy of your special attention, for the reason that it seems an anomalous one. This seems to disprove the truth of the saying that "sleep is tired nature's sweet restorer." One should naturally feel better after sleeping, but the reverse is true of the *lachesis* patient. She is always worse after sleeping. It is doubtful if you will find this symptom in the Revised Materia Medica. But I desire to impress the fact upon your minds emphatically that it is a symptom of *lachesis*; and, moreover, one of its most reliable and valuable symptoms. We next find that this patient is troubled with chills at night and flashes of heat by day. This symptom is similar to that of *sulphur*, which is a remedy that probably has no superior in the treatment of ailments peculiar to the climateric period. The difference being that the *sulphur* patient has the heat at night and the chills mostly during the day. Another reliable symptom of this patient is an intolerance of the pressure of her clothing about her neck, or about her chest and abdomen. She says this pressure causes no pain, but simply a sensation of nervous discomfort. When the clothing about her neck is at all snug she complains of a nervous choking sensation; when she is conscious of the pressure about her chest or abdomen her impulse is to take hold of the clothing and loosen it,—pull it away from her body.

These are the only peculiar symptoms of this patient's condition, all the rest are common to a great number of other medicines; but these taken together with the others make a perfect picture of *lachesis*; and you may depend upon it that where you find this picture, with these emphasized characteristic symptoms, *lachesis* will invariably better your patient's condition. We will therefore prescribe this remedy.

The second case is a woman about the same age as the other; she also is suffering from the distress of the climateric period. In addition to the common symptoms of that change we find this patient suffering from intense headache. Her chief complaint is about this headache and her rest-

lessness at night and "poor circulation," as she calls it. The character of the headache is burning, especially upon the vertex. She says the top of her head is so hot she wants ice or cold cloths continually upon it; at the same time her feet are very cold during the day, and extremely hot, especially on the soles, during the night. She says this latter symptom is so persistent and annoying that her sleep is greatly disturbed thereby. She continually changes their position while in bed in order to find a cool spot for the soles of her feet, even placing them against the wall for the purpose of cooling them. She complains of frequent and annoying hot flashes which are followed by a weak and clammy feeling; she complains further of distressing, gone, empty feeling in the abdomen, which causes her to eat something an hour or two before the noon meal and the same before the evening meal. She is also sleepless; waking frequently during the night. Unlike the *lachesis* patient she feels better for her sleep. As is nearly always the case when *sulphur* is the remedy in such conditions, she passes at times great quantities of colorless urine; occasionally the opposite being the case, when she passes small quantities of highly colored urine. Where you find this group of symptoms during the climacteric period you may confidently rely upon *sulphur* greatly ameliorating the woman's condition. We will therefore prescribe sulphur in her case.

The next patient is a young woman aged 23; her complaint, as she expresses it, is dyspepsia. She complains of a burning in her stomach and the whole length of the œsophagus; sour belching, loss of appetite, even to aversion for food, especially has she no appetite for breakfast. A certain anæmic appearance which she presents suggests to us that probably the stomach is not the original cause of the trouble in her case. On questioning her in regard to her menses we find that she suffers, and has suffered since her first menstruation, which occurred at the age of fourteen, from dysmenorrhœa. She suffers headache and abdominal pains during the first two days of menstruation; during this period also her symptoms of indigestion are aggravated. Further inquiry develops the fact that, although as a girl she was warned against the danger of exposure about the menstrual period, she took cold during her first menstruation by wading through the snow a considerable distance to school; that the flow was arrested and that she was ill for a short time in consequence. Her next

menstrual period and every succeeding one has been attended by the distressing symptoms named; neither has she been perfectly well in any respect since that time.

It is too often the case that girls, through false delicacy or ignorance on the part of mother or sister, are left in ignorance of what is coming, and of the care that must be exercised at that time. No mother, I might say no physician, performs his or her full duty to child or patient who does not instruct girls in this matter. If this were done intelligently and conscientiously one-half the ills from which women suffer could be avoided; and the highest duty of the physician is to prevent sickness rather than to cure the sick. The same facts make this true that make true the old saying that "an ounce of prevention is worth a pound of cure."

In addition to the symptoms common to this class of cases we find the following symptoms peculiar to this girl: Her mental condition is first noticeable, she being much depressed in spirits, despondent, discouraged, etc. With her, mole-hills of duty seem mountains of labor—even as she details her symptoms tears come into her eyes. As she said before, her appetite is very poor—especially at breakfast—and that anything in the form of greasy food is especially obnoxious to her, and, if eaten, causes an aggravation of the symptoms of indigestion of which she first complained. She complains also of a very disgusting taste in her mouth in the morning; of much headache, which is aggravated while in a warm room, and is as uniformly relieved by going into the open air. The reverse of this condition is true of *nux vomica*, which may be called the male complement of *pulsatilla*, and its nearest relative in the treatment of patients suffering from indigestion. This group of symptoms is a perfect picture of *pulsatilla*, and you will find that this remedy will inaugurate an improvement that careful following up will result in a cure for this girl, not only of the dyspepsia, but of the dysmenorrhœa as well.

This case well illustrates the necessity and advantages of considering the totality of the symptoms in every chronic case that you try to cure. It is evident that the chief cause of this patients' "dyspepsia" is traceable to the irritable condition of the uterus, and this irritable condition of the uterus is directly traceable to the cause of her dysmenorrhœa, namely, the cold taken by getting her feet and limbs wet tramping through that snow-storm to school ten years ago.



It would be well to note that when we speak of the totality of the symptoms we do not mean only such morbid phenomena as the patient experiences at present together with such objective symptoms as we can observe, but we must include every fact in the history of the patient, or even in the disease-history of her parents, and the probable exciting cause which developed the existing condition. Probably the most valuable symptom in this case, in directing us toward the right remedy and diagnosis, is the circumstance of her wetting and chilling in that snow-storm when she was fourteen years old. Had we considered only the symptoms presented by the patient, together with such symptoms as we can observe in her now, or had we taken her own diagnosis of dyspepsia as our guide, we would have lost sight altogether of the most valuable symptom in her case. We would have consequently failed both in the diagnosis of condition and remedy, and the result would have been at the best doubtful; whereas, we can now, with the utmost confidence predict, if not a cure, still great amelioration of the patient's distress.

Contrast this scientific mode of making a prescription with that adopted by a certain old school college in this city and we may congratulate ourselves. In the clinics in that institution the diagnosis of the patient's disease is made as carefully as may be. The physician then turns to a large card hanging on the wall behind him, on which is printed the various diseases. Under these names of diseases are lists of compounds for the treatment of the respective ailments, numbered according to their supposed importance. After the diagnosis has been made No. 1 of the list of drugs used in the treatment of that disease is given to the patient. The patient returns on the next appointed day and reports better or worse. If no better, No. 2 on the list of drugs is given, and so on to the end of the list. This is a "regular" clinic.

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NOTE.—The third case discussed above, reported one week after receiving the medicine that all her symptoms were in a great degree relieved, some of them being entirely removed, viz. low spirits, headache, loss of appetite, etc. In her own words: "The change for the better is wonderful."

## Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

SEPTEMBER MEETING, 1889.

The regular monthly meeting of the Clinical Society was held at the Grand Pacific Hotel, Saturday evening, September 28th. Forty-four members and students were in attendance. After the ordinary routine business was disposed of the Society listened to the

### *REPORT OF THE BUREAU OF OBSTETRICS.*

DR. SHELDON LEAVITT, CHAIRMAN.

I. HEMORRHAGE AFTER MISCARRIAGE.—By SHELDON LEAVITT, M. D.—Some of the most vexing annoyances of obstetrical practice, encountered by the solicitous and pains-taking physician, arise in connection with premature expulsion of the ovum in the early months of pregnancy. They are not all real emergencies; but, by pertinacity, they often become as trying to all parties concerned, as are emergencies, even if not invested with equal peril to the patient.

If medicine were only the exact science which we would like to make it, and which even now some would have us believe it has, in their hands, become; if we at will could bring inimical symptoms into line, and train them into docility and order; if, by exhibiting a carefully chosen remedy, we could, with certainty, set in corrective, healthy activity the vital forces of the organism, as in these days of ingenious contrivance we can start up a train of ordinary mechanical effects by dropping a nickel into the proper slot, the practice of medicine would become, what it is not always now, a most delightful calling.

You have seen certain coin-catching devices soliciting

your patronage which would take in any number of nickels, but which, from some anomalous or unknown cause, refused to perform their promised response. With vexation and chagrin akin to that which you then felt, but, of course, greatly intensified, do we sometimes wait in vain for effects from the applied remedy, while the ailment pursues, without abatement or consequent deviation, the stubborn course upon which it has entered.

There are no unfailing specifics. Every rule has its exceptions; but there are some rules whose exceptions are few, and to one of the latter I wish this evening to call attention. Here it is:

*Profuse bleeding after abortion is occasioned by retention in utero of the whole, or a part, of the membranes; and can be controlled by thorough removal of what has been left behind.*

This is a rule which doubtless has its exceptions; but they are few. In my own practice I have never observed one, although, in the case about to be recited, I, at one time, felt sure that one was about to be disclosed. Let me give you the case, and then, with the foregoing rule as a text, and this as an illustration of its application, you will suffer me to offer a few observations.

Mrs. B. aet. about twenty-six years, a woman of medium height, fair complexion, rather slight build, the mother of one child about three years of age, miscarried July 6th last, at the third month. I removed both fœtus and secundines from the cervix uteri, where I found them successively presenting, by means of the finger. Hemorrhage, which had been rather free, at once ceased, and I made no other visit for three weeks, and then I went in response to an urgent summons. I found that my patient had done well, and had been not only about her rooms, but to the house of a friend, living some three blocks away. The occasion of my call was a sudden and rather profuse hemorrhage, unaccompanied by pain. I sent her back to bed and kept her there for a few days. All flow ceased, and she had subsequently again gotten about her rooms, when there came a repetition of the former experience. The os

uteri would not admit the finger, but the cervix was seized with volsellum forceps, and the dull curette passed over every part of the endometrium, without finding anything beyond little stringy coagula. There followed for a few days an interval of slight, but continuous, flow, broken at times, by a more profuse loss.

Among the hemorrhages was one so exhausting that I decided again to curette, this time under slight anæsthesia; but nothing beyond fragments of coagula was removed. There was temporary improvement; but I dared not let her get out of bed; indeed, my patient became so alarmed at her condition that she could not be induced to raise her head, and whenever there occurred even a slight flow, she became panic-stricken, and almost uncontrollable. Various remedies were administered in different potencies, among which were *secale*, *sabina*, *hydrastis*, *caulophyllum*, *phosphorus*, and *pulsatilla*. Meanwhile the cervix had resumed nearly the non-pregnant size and feel, but the uterus measured three and a quarter inches in depth. Finally, stung by my want of success in controlling the flow, I resolved to curette the womb a third time. On September 8th the patient was fully anæsthetized, the os forcibly dilated to the breadth of one and a quarter inches, with Goodell's dilator, and every part of the endometrium was twice visited with the dull curette. With a swab of cotton on an applicator I then wiped over the same surfaces with tincture of iodine. Upon carefully examining the small quantity of detritus removed with the curette, I found chiefly coagula, and of organized substance not more than could be laid on a silver three cent piece. There was a slight stain on the napkin during the succeeding forty-eight hours, and none whatever since. The patient is now sitting up several hours a day, and doing well. (She menstruated normally October 5th.)

Let us now inquire, what are the conditions which determine undue loss of blood after abortion.

Certain women have what is called a hemorrhagic diathesis, which expresses itself in the loss of unusual quantities of blood on the slightest provocation. With a consti-

tutional condition so favorable to hemorrhage, we are not surprised to see them suffer exhausting depletion during and after abortion.

Between healthy women there is a great difference in proneness to hemorrhages. Whether this is due to a modified constitutional bent, of a nature like that just alluded to or not, I am unable to say. One woman will miscarry, and, perhaps, even retain the afterbirth for days or weeks and not lose much blood; while another will flood nearly to death during the ordinary course of a well-managed and promptly-ended miscarriage.

Post-partum hemorrhage with labor at full term is much more likely to occur after the uterus has been entirely emptied; while that occurring in connection with abortion is far more prone to set in as the result of incomplete evacuation of the womb. This difference in clinical phenomena admits of easy explanation. Blood loss after labor depends on imperfect contraction of the uterus, and hence a patulous state of the torn blood vessels at the vacant placental site. After abortion, the uterus is small, the torn vessels few, and of small calibre; but under the pressure of a vascular fullness set up by energetic efforts of the organ to expel whatever remains in its cavity as a foreign body, relief of the tension finally comes through two avenues, namely: the larger vessels at the site of ovular implantation, and the capillaries of the endometrium.

The mere occurrence of hæmorrhage at such a time, ought not to be construed as conclusive proof of dereliction on the part of the medical attendant, though we are fully justified in regarding it as *prima facie* evidence of incomplete uterine evacuation. The ovum may come away intact, and yet in some women annoying, and even serious, blood-loss ensue. The decidua vera breaks down after premature expulsion of the ovum, and comes away piecemeal; which process is usually marked by no conspicuous phenomena; but which in certain cases is accompanied with long-continued drainage and occasional active hæmorrhages. In the instance which I have before recited, I was not de-

relict of duty, and did at first for my patient what in almost every case would prove sufficient to carry it to a satisfactory termination. When suspicious symptoms arose, I curetted the womb as thoroughly as I had ever found it necessary to do in order fully to control hæmorrhage. Before operating the third time, I told my patient and her friends, that, while I was not conscious of any neglect in my management of the case, I could not consider a physician who might be called to attend her any more unjust than I myself would be under like circumstances, without knowledge of what had been done, should he declare that skill in the management of the case had become conspicuous by its absence.

For temporary arrest of such hæmorrhages nothing has served me so well as hot vaginal douches; but for permanent relief, resort should be had to the curette.

Among our homœopathic remedies there are some which often prove helpful. Following are those from which I most frequently make my choice: *Secale, sabina, pulsatilla, ustilago, trillium, china, ipecac., calcarea carb.*, and *phosphorous*.

DR. W. J. HAWKES: Dr. Leavitt's paper has interested me. The principal criticism I would offer is first, that in the remedies he has mentioned as having used in the case, two of those that have been of the greatest service to me in similar conditions, have not been mentioned by the doctor. Those are *calc. carb.* and *trillin*. It seems to me it would have been a wiser course, after having once and even twice curetted the womb, to have made a more careful study in search of the probable constitutional condition which permitted such an undesirable condition to exist for so long a time, and then to have made a thorough search for the indicated remedy to correct that condition. In similar conditions I have found *calc. carb.* would correct the whole difficulty. I have a case in mind where a fleshy, leucoplegmatic woman frequently has been subject to such spells of hæmorrhage of long-continued periods of flowing; it frequently occurred that she would flow from one period

to another without cessation. In this case to be sure there had been no miscarriage, nor other accident to cause the hæmorrhage. It seemed to be a constitutional trouble altogether. *Calc. carb.* was the indicated remedy, and it would invariably correct the difficulty in from three to five days. I believe therefore that had Dr. Leavitt found the immediate remedy, there would have been no need for a second and third curetting of the uterus.

In regard to the statement in the paper that homœopathy or the "science of therapeutics" was not an exact science as is astronomy, chemistry, etc., I have to say that were the "Science of therapeutics" rid of its many sources of error, it would be an exact science as in the others mentioned. Among these inevitable sources of error are that the person who procures the substance—drug, mineral or salt—is finite and liable to error; so also is the pharmacist who prepares and sells the substance, and the physician who prescribes it for the sick; and the patient may have a mental and moral obliquity and deceive the physician, and so on. Were these inevitable sources of error removed from the administration of homœopathy, the "science of therapeutics" would be as exact as the others.

DR. R. LUDLAM: I consider the paper very practical. At present the use of the curette is regarded as very proper in such cases. As there were no fragments of the secundines remaining, or disease of the endometrium to account for the hemorrhage, would not some other means have been as effectual? My theory of the case is, that it was one of uterine sub-involution, and that the operation stimulated the involution, which possibly might have been brought about earlier by some other means. Contraction is Nature's method of controlling uterine hemorrhage. Nothing will cause contractions to occur quicker than to bring something in contact with the uterine mucous membrane. In this case it is possible, I think, that the application of the iodine did more to cause uterine contraction than did the use of the curette. The curette did good in that it satisfied the Doctor that there was no other cause

to account for the trouble. In his hands the curette was safe enough, but its indiscriminate use by unskilled practitioners is apt to result in great harm to the patient. Electricity will accomplish much in these cases. I think that hot water, carefully injected into the cavity of the uterus, would have been as efficacious in relieving the hemorrhage as the means employed.

**DR. A. K. CRAWFORD:** In uterine hemorrhage we may have the same condition as exists at times in other parts of the body. Thus, in hemorrhage from Peyer's patches in typhoid fever, we find that the ulceration has opened a large number of small blood vessels, but it is very seldom that a vessel of large size is affected. In the fatal termination we believe the result directly attributable to a vasomotor paresis, allowing such an escape of blood from a number of small points that the system cannot react. The same condition exists in pulmonary hemorrhage. Occasionally we have a large vessel ruptured, but the results of post-mortems show that the blood usually comes from a great number of small vessels.

**DR. J. P. COBB.** I have found electricity of great value in uterine hemorrhage, from lack of contraction; especially when the blood comes in gushes. One great advantage of its use is, that the results are observed immediately.

**D. OTTO POPPE:** How long since the curette was last used? Is the hemorrhage not liable to recur? It seems as if the intervening time was too short to pronounce the case cured.

**DR. LEAVITT:** The last curetting was done three weeks ago. From the fact that the flow has entirely ceased since that time, and from the present condition of the patient, I think she is rid of the trouble. Of course she will have the customary flow at the month.

**DR. E. S. BAILEY:** This case presented itself in an acute form. Such cases if neglected often run into a chronic condition that may last for years. There is a case at present in the clinic which illustrates this: Nine years ago, after an induced abortion, she suffered from a profuse hemor-



rhage, which has repeated itself at the month ever since. Some years ago she was examined by a physician, who passed a sound into the uterus. Its introduction caused such a profuse hemorrhage that her family has forbidden her to allow such an examination again. In these chronic cases the endometrium may degenerate into a cancerous condition. . Masse says that the electrode will eventually supplant the curette in intra-uterine troubles.

DR. LEAVITT: I did not use the remedies suggested by Dr. Hawkes, as they did not seem indicated. I believe that the small amount of organized *débris* removed had considerable to do in accounting for the hemorrhage. From the rapid recovery after the application of the Iodine I think the results were due to it rather than to subsequent involution. When examined at the time of the last curetting the cavity of the uterus was only a quarter of an inch above the normal, and so slight an enlargement could scarcely account for so severe a hemorrhage.

Electricity would, no doubt, have been a good agent. A strong galvanic current, several times repeated, would probably have answered as well as the curette. The dull curette is, as far as I can learn, a safe agent. The sharp curette, especially if used with much pressure, is a dangerous instrument, and must be used with great care.

DR. LUDLAM: As the sound was used but once, we do not really know whether or not the uterus had contracted and shrunken after the first operation.

DR. LEAVITT: I am satisfied that involution had been progressing for some time, but the hemorrhage continued without diminution.

II. PLACENTA PRÆVIA—BY DR. E. G. H. MIESSLER, OF CHICAGO.—*Case*: June 14th I was called to see Mrs. C., aged 21 years, of French descent, then being in the ninth month of her first pregnancy. The husband reported that his wife had been flooding very profusely for several hours and that they feared a premature labor. On my arrival I found the patient on her bed bleeding badly, but there was no sign of labor. She did not think that she had sustained

any injury which might have caused that severe flooding, but the land-lady told me that the young woman appeared to be very careless as to her condition, that she would fly up and down the stairway as if nothing was to be feared, and that she was fond of dancing and that only a short time since she had been to a dance. Guided by this narrative and assuring myself by a digital examination, that labor was not in progress, I first gave a few doses of *arnica*, and with a view to stop the flow, which was alarming, I prescribed *china* 3 and *ipsecac* 3, to be taken in rotation, and ordered the patient to remain in the recumbent position with her head low, and to report, if any change for the worse should occur.

On the following day at 5 P. M., I was called in haste by the anxious husband, who reported that the patient had had labor pains for quite a while, that the flooding was some better, but had not entirely ceased. On my arrival I found her rather weak from the loss of blood—feverish and excited from fear that something bad was awaiting her. By the uterine contractions, which were strong and very annoying, it was evident that labor was in progress. On examination I found the os-uteri entirely out of reach, high up in the hollow of the sacrum—so much so, that during a pain I could not even reach its anterior lip. During every pain I reached with the index finger of the right hand for the displaced os, while with the left hand I made upward pressure externally, thus succeeding after some efforts to hook my finger in the os and to bring it in to position. But what I had gained during a pain, I lost again in the interval, until I held the os uteri in place with my finger even in the absence of the pains, thus overcoming the displacement of the uterus. The os was soft and dilatable, and the uterine contractions went on regularly and with dilating force. In spite of the administration of the best indicated remedies the hemorrhage did not cease entirely, which made me fear that I had before me a case of the so-called “unavoidable hemorrhage”—placenta prævia—and this fear I found verified as soon as the os was dilated enough to reach for the presenting part. Instead of finding any part of the fœtus presenting, my finger came in contact with a soft, pulpy substance covering, as it were, the entire os uteri. It was evident that I had a case of placenta prævia to deal with.

Having made my diagnosis I related the case to the patient and her husband, the only ones present at the time,

and after having fully explained to them the nature of the case before us, I asked the privilege of calling a consulting physician to help us through. Accordingly I telephoned for Prof. Leavitt, who kindly responded to the call in spite of the late hour in the night and the great distance. On his arrival Dr. L. corroborated my diagnosis. On account of the hæmorrhage which was still present, it was deemed necessary to hasten delivery. Anæsthesia was applied, to which I attended, leaving the harder part of the operation to the skillful hands of Dr. Leavitt.

A more thorough examination could be made now, which revealed that the placenta covered the whole os, and that above the placenta the fœtal head was presenting. The next proceeding was to work through the placenta and to apply the forceps to the fœtal head, and this Dr. L. tried to accomplish; but the application of the forceps was much easier suggested than accomplished. It was found to be exceedingly difficult by reason of the fœtal head being very high, the os not being fully dilated for an easy entrance of the two blades, besides the trouble caused by the placenta being in the way. But after some considerable effort Dr. L. at last succeeded in applying the forceps as well as could be done under these trying circumstances. Traction was now applied and pressure made externally upon the fundus uteri, while the patient was supported by two strong men—father and husband—but no perceptible progress was made towards delivery for a long time, it requiring all the strength that could safely be applied. When the head came down into the inferior strait it was found necessary to remove the forceps, the fœtal head being rather in an oblique position, and to apply them anew so as to bring the head into the corresponding diameter of the pelvis. This being done labor went on without any further trouble. A female child was born but it was a still-birth, and all efforts to restore its life were of no avail.

Quite troublesome to the accoucher and painful to the patient was the delivery of the placenta, which was adherent to the walls of the uterus to a considerable extent and had to be peeled off all around, which was accomplished while the patient was kept under the influence of chloroform. This being done she was put to bed comfortably and otherwise taken care of, although very weak and exhausted from the great loss of blood. The flooding went on more or less until the placenta was expelled. She rallied well from the anæsthetic and made a good and perfect re-

covery. On the eleventh day she commenced sitting up, and from that time gradually regained her full strength. The remedies prescribed during her lying-in were the following: *Acon.* and *arnica* (in most cases my very first remedies), *bella.*, *bryonia*, *ver. vir.*, *china* and a few others, according to their especial indications.

III. A CASE OF PLACENTA PRÆVIA.—BY A. T. HARRIS, M. D., OF ENGLEWOOD, ILL.—*Case*: I was called July 24th, to see Mrs. A. G., a strong German woman of 41. Found that she was about seven months advanced in her thirteenth pregnancy, and had been flowing freely for the past twenty-four hours. Said that she had never any trouble with her previous pregnancies, but had not felt right at any time with this one. Had suffered much with nausea, poor appetite, and constant weak, bad feeling. The day before, while under considerable mental strain and excitement, the flow suddenly appeared, at first very profuse, and then moderately. I at once ordered her to bed, and gave a vaginal injection of hot carbolized water, which entirely stopped the flow. An examination revealed the lower segment of the uterus considerably thickened, the os rather high, pointing backward, and undilated, with no presenting part in reach. I feared trouble ahead, but did not attempt a more thorough examination, for fear of bringing on a renewal of the hemorrhage. Gave *puls.* and *china*, and ordered her to keep quiet. She obeyed the order for 36 hours, when finding no flow, she concluded that the danger was past, got up and went to work. Before night the flow returned and she sent for me.

I repeated the hot injection, and the flow stopped. Gave *hamamelis* and *china*, and ordered her not to get up for any purpose.

On calling the next morning found my patient with no flow, but a temperature of 103°. Said she was awakened at 1 p. m., with a hard shaking chill, lasting an hour, and followed by fever and headache. Gave *ars.* and *verat. vir.* By evening the temperature had dropped to 102°, and next morning was 101°. By next day it was normal and so continued. No appetite, tongue coated, very thirsty, and feeling of great prostration, profuse sweat on sleeping.

Things continued in this way for another week, when I was called hurriedly at 10 p. m. Found that she had been flowing profusely; came on while sleeping, without pain or warning. A hot injection entirely stopped the flow.

Gave china. Had just got into bed when my telephone called me back; the flow had again appeared moderately. Repeated the injection with good results, and called in Dr. Foster. We agreed that delivery must not be long delayed, and called Dr. Leavitt on the morning of August 10th.

After an examination by Prof. Leavitt, we decided that an immediate delivery offered the only chance for either mother or child. After placing the woman under chloroform, Prof. L. rapidly dilated the os with his fingers, forced his way through a centrally implanted placenta, brought down the feet, and hastily delivered the child, the placenta following easily.

During the delivery the hemorrhage was frightful, but almost ceased after its completion.

Patient came out from the anæsthetic soon, but the pulse was very feeble, uterus contracted, spasmodic under friction, pressure and hot injections, but the flow was inclined to return.

After the departure of Drs. Leavitt and J. M. Foster, the slight flow continued, and I kept up pressure over the fundus, gave hypodermics of ergot, with but slight effect; repeated the hot injections and as the pulse grew faint injected whisky. Tried pieces of ice passed into the womb, and finally saturated a ball of cotton with persulphate of iron which I crowded well into the uterus.

All was of no avail, and she ceased breathing about two hours after delivery, the child following about three hours later.

What was the cause of that chill and the fever on the fourth day; and when is interference justifiable in these cases?

DISCUSSION.—The reading of the last two papers elicited the following discussion:

DR. G. A. HALL: These cases are frightful. Many times lives are lost because the condition is not recognized. Aside from traumatism, or other accidents, where you have frequent and severe hemorrhages after the fifth month you may suspect placenta prævia. When such a case is recognized the physician should always be within hailing distance or should have somebody near to attend when the hemorrhage becomes severe. If I were satisfied that I had a case of placenta prævia to deal with I should institute proceed-

ings at once. In the case last reported I think death resulted from loss of blood. The patient might possibly have been saved if delivery had been produced earlier. I think the chill was due to the decomposition of a small clot. The amount of septic matter being small the system was able to throw it off.

My first case of placenta prævia occurred in an Irish washerwoman, early in my practice. As I entered the house the first thing I noticed was a river of blood running across the floor. The woman was very large and plethoric. On examination I found the os large and very soft all around. (When the os is found large and presents a sense of puffiness all around to the touch you may be almost sure of placenta prævia.) The os was the size of a two shilling piece and a soft pulpy mass presented. I immediately packed it with pledgets of cotton soaked in the strongest vinegar that I could get, carrying them up with the forceps until dilatation had progressed, when I hastened the dilatation by introducing my hand into the os and then closing it tightly. As soon as possible I forced my hand through the placenta and brought the head down. A strong pain then forced the head firmly down and checked the hemorrhage for the time. In addition I used injections of vinegar into the rectum and had a compress wet in vinegar placed over the abdomen, together with firm pressure on the uterus from above downwards. The pains now continued at regular intervals for two hours, accompanied by only a slight loss of blood, when the head was delivered. The delivery of the child was followed by a profuse flow of blood, which was controlled by introducing the hand and removing the placenta—after which a tampon, soaked in vinegar, was carried into the womb. The patient recovered.

Acetic or citric acid is a valuable means of inducing contraction of the blood vessels. Half of a lemon carried into the uterus, and then squeezed, will frequently control a hemorrhage otherwise uncontrollable.

I have never had over ten or eleven of these cases in my thirty-four years' practice. I have been called to oth-

ers in consultation, and have arrived in time to see the patient die, or to operate successfully. Have only had one death from this cause.

The proper time to interfere is as soon as the condition is determined upon, or at the latest as soon as the first severe hemorrhage occurs.

DR. W. A. BARKER: I have had two cases of placenta prævia, but both were comparatively simple compared with those just described. In one the placenta was centrally attached. The hand was forced through, and the podalic version performed. The placenta came away in two pieces. The child was still-born, but the mother recovered.

In the second case there were twins, and delivery occurred at the seventh month. The placenta of the first child was central. The child was turned and delivered. The second child came naturally. The latter had an independent placenta that was located normally.

DR. R. LUDLAM would emphasize Dr. Hall's remarks, and would also take occasion to advise the Members not to forget the old expedient of *perforating* the placenta in these cases, and thus gradually evacuating the uterus of the liquor amnii. This little operation, which any one could make, in case the woman was at term or not, would arrest the flow by plugging the cervix from within, and the contractions induced would put a sort of Esmarch's bandage on the organ so as to prevent an excessive loss of blood. His attention was first called to this expedient in placental presentation by Wielobycki, of Edinburgh, who many years ago published a number of cases in which, by perforating the placenta with a female catheter, the lives of the mothers and children had been saved. Essentially the same method of treatment is advised and strongly endorsed, if I mistake not, by Guernsey.

DR. G. A. Hall: At what period would you counsel this interference?

DR. LUDLAM: Just as soon as unavoidable hemorrhage in a pregnant woman is recognized. One great merit of the

method is that it is applicable at any and all periods of gestation. The early conditions that would justify its use would not permit of a recourse to version, the separation of the placenta, or any other method that has been prescribed. To pass the catheter carefully between the sulci, along the margin of the placenta, if it is possible, and through the membranes, thus drawing off the water gradually, will precipitate the labor and put an end to a condition that only becomes more perilous by delay.

DR. HALL: But as soon as you have uterine pains you will have the blood come away by gushes, and thus cause the very trouble you wish to avoid.

DR. LUDLAM: The expulsive effort forces the presenting part of the fœtus, which almost always in these cases is the head, into the cervix, and compresses the bleeding vessels so that the labor has a chance to be finished physiologically, or later on can be terminated by the forceps.

DR. W. J. HAWKES: I agree with Dr. Ludlam in the use of the catheter. Anything that causes the uterus to contract will arrest the hemorrhage, and the drawing away of the fluid prevents an atonic condition of the uterus. The hemorrhage of placenta prævia is characteristic, and not to be accounted for in any other way. Deliver as soon as the condition is recognized.

DR. LEAVITT: I object to the use of the catheter, because if it should be necessary to practice podalic version its performance would be very difficult. If we are to interfere at all why should we do so in advance, for when we deliver the child the operation in itself will be sufficient to bring on contractions.\*

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\*[*Editorial Note.*—It may interest some of the readers of the CLINIQUE to know the facts set forth by Dr. Wielobycki, in his paper published in the *British Journal of Homœopathy*, Vol. IV., 1846. In discussing the relative merits of turning, and of perforation, in total or central placental presentation, he gives the full details of twelve cases of the kind in which, by means of drawing off the liquor amnii slowly through the catheter, he had saved all of the mothers, and all of the children but three, two of which were born at the sixth and the



VOLUNTEER PAPERS—I. CASES FROM PRACTICE. By O. B. HANSEN, M. D., of Copenhagen, Denmark. *Concluded* from page 338.

*Case 6.* NAJA IN CARDIAC RHEUMATISM.—O. L., 32 years old. Eight years ago had rheumatism in the joints, yet without any pains in the heart, but with a long-lasting and high temperature. Six years ago he had lues. The present illness came on suddenly, February 16, 1885, with the following symptoms: Pressing pains in the crown of the head as if from a weight; asthma during the last few weeks; palpitation of the heart when walking or resting on the left side; and he feels as if his heart was shrinking. Great fear, no appetite, stools normal. Percussion shows an increase in the breadth of the heart, but the length is normal. No friction sounds; the first heart-beat is followed by a scraping dissonance, the second is accentuated. The pulse is irregular, somewhat weak; the lungs are normal and the urine likewise. *Cactus grand.*, three drops every three hours.

February 28. No improvement. He complains of heavy pains around the heart and in the neck, in the left shoulder and left arm, and the pains are accompanied by mortal fear. The fits came often during the night, at intervals of different length. Aconite, arsenicum, arnica, spigelia, kalmia, phosphorous, convallaria, lachesis, etc., were given without effect. At the close of March his condition was but slightly improved. He now complained of a dry

other at the eighth month. The paper contains parallel columns on the *advantages of perforation* and the *disadvantages of turning*, that we would be glad to reprint if our space would permit. Dr. Guernsey (*Obstetrics*, 2d edition, 1873,) says of perforating the placenta with the catheter in these cases: "I have not heard of a single case of loss of the mother where this method of procedure has been followed, and the child is almost invariably saved. It must be remembered, to evacuate the liquor amnii very slowly. Every accoucheur knows what bad effects follow the emptying of the uterus rapidly under such circumstances; the atony thereby produced is more to be dreaded than the former state. When the placenta is only partially over the os, even if it be but the edge of it, the same principle and practice hold good."]

cough, especially from the trachea, accompanied by pains in the cardiac region. *Naja tripudians* 3, three drops four times a day. After two or three days there was considerable improvement. The pains and the other symptoms decreased. Yet the recovery came very slowly, and he was not well before the middle of May. A slight roughness is still heard at the first heart-beat. Continued the naja for six weeks, morning and evening.

My opinion is that the defect of the heart originated from the rheumatism in the joints. The fits were exactly like those of angina pectoris. The indications which led me to prescribe naja were the pains in the head as if from the pressure of a heavy weight, and the dry tracheal cough, accompanied by palpitation of the heart.

*Case 7. BELLADONNA IN CEREBRITIS.*—T. J., a manufacturer, usually of good health, has now been ill for ten days, during which time he has had old-school treatment without any benefit. As his present state grew unbearable, he began to be treated homœopathically on the 18th of November, 1885. He has a severe headache with throbbing pains especially in the crown of the head and the neck, often with decided jerks in the head. This suffering is worse when moving the eyes or hearing a noise, and better when pressing hard upon the head with the hands. Heat in the head without congestion; vomiting of water and mucus. The pupils are enlarged, he has no appetite, is sleepless, the tongue is white-coated in the center and moist. He has not slept for the last eight nights. His stools are difficult, yet light-colored and not hard. He is worse in the middle of the night. *Belladonna* 3, three drops every second hour.

November 19. Much better. Has slept three hours last night. Same prescription. His former physician declared the disease to be cerebritis, but that all danger was passed. By the continued use of the belladonna four times a day, he came out of bed the 21st of November, and was quite recovered at the close of the month.

*Case 8. CALCAREA CARB. IN CHRONIC METRITIS.*—Teacher P.'s daughter, 21 years old, was treated by me two years

ago for hemoptysis. Now (January 17, 1886) she has been ill for six months. Fatigue, emaciation, dizziness and stinging pains in the forehead across the eyes, which is better when in the open air. Every second month she has qualms and fainting fits with convulsions in the arms, and is unconscious during the fits. Pressing and squeezing in the pit of the stomach. The menses are very copious, with a thick yellow leucorrhœa, especially when in motion. The stools are hard and tough, and are passed every second day. The appetite and sleep are poor. Thirst. In the region of both of the clavicles the respiration is rough and weakened. The uterus is decidedly flexed, and there is much soreness when pressing on the right para-metrium. The urine is normal. *Sepia* 12, three drops three times a day.

February 10. No change. *Sepia* 30, three drops morning and evening.

February 24. Her condition is worse, and her spirits are greatly depressed. The fatigue is worse at the beginning of the day. Palpitation of the heart. Stinging pains in the vagina as if from knives; often changing color in the face. *Calc. carb.* 30, three drops twice a day, morning and evening.

April 3. Considerable improvement. Appetite and sleep good; good spirits also. Same prescription. In the beginning of June she was quite well. During the treatment vaginal injections of warm water were also employed.

*Case 9.* SULPHUR IN PLEURISY WITH EFFUSION. C. P., twenty years old, came under treatment October 8, 1886. He has been scrofulous, especially in the cervical glands: wounds and sores in the nose and choking up of the nostrils. Has been treated in the Commune hospital from the middle of June to the beginning of August, 1886. The diagnosis was pleuritis sinistra with pericarditis. His thorax has been tapped and five pints of water taken without being cured. He has been at times taken with bleeding from the nose, but never a cough or hemoptysis. The appetite, stools and sleep are good, but he has dyspnoea on the least

exertion, with stinging pains in the left lung beneath the scapula, and likewise a little pain in the right lung, but no fever. His mother died of consumption. Percussion very dull from the angle of the left scapula downward. Resonance of the voice and enfeebled respiration. Hard and long breathing in the right infraclavicular region. The heart itself is normal. *Sulphur 30*, three drops three times a day.

October 20. All the symptoms are better. Later I gave the patient *Arum triph.* 3, three drops three times a day for a watery catarrh from the right nostril with closing up of the nose, and excoriation of the nostrils and the upper lip. There was no polypus in the nose. He was at the beginning of December quite well. A relapse of the pains in the chest recurring at the close of April, 1887, he was soon restored with *Sulphur 30*.

*Case 10. ECZEMA.* F., a ship-owner, forty-three years old, began treatment November 14, 1886. During the last twenty years he has often had eczema, especially in the spring and fall. The old-school treatment with ointments and arsenic pills did no good. The eruption which discharges water, has its seat in the forehead over the eyes, near the edges of the hair and on the cheeks. The skin is red and thick, and the eruption scales off in small particles with itching and burning. It often shows itself on the fingers, and spreads over the arms and legs, and also on the back, otherwise he is quite well. I first prescribed *Rhus tox.*, 1, *Arsen. alb.* 6, and *Croton tig.* 3, but without any visible change.

In the middle of January, 1887, *Rhus. venenata* 3, three drops three times a day had a good effect. In a few days the eruption was dry and the itching had considerably diminished. It went on well until the middle of February, when the eruption came back. I then gave *Sulphur 6*, three drops morning and evening, after which there was improvement until the middle of April, when it returned as before. I again prescribed *Rhus ven.*, and in the beginning of June the eruption had quite disappeared.

2. A CASE OF ECZEMA CAPITIS. BY DR. W. R. WELCH, OF HERINGTON, KANSAS.—After reading in a late number of the *Medical Advance* the report of an eastern physician decidedly recommending the practice of mixing medicines as more efficacious than the giving of single remedies, I was at once reminded of a case of eczema capitis which came under my care. I wish to report the same to the Clinical Society for the consideration of its members.

*Case.* About two years ago a lady patient of mine who lived some distance in the country, brought her baby ten months old to me for treatment. It presented the following conditions:

The child was fleshy and of a ruddy appearance and *seemed* quite well, but the whole head, with the exception of the face, looked as though it had been plunged into a chest of bran. The scales were very large except on the occiput, where there were several spots the size of a pea and larger that were covered with thick crusts.

From beneath these crusts there exuded a sticky, yellow fluid. Behind the ears were very large patches also thickly covered, and under them I found the same honey-like fluid. The child was almost without hair. When I placed my hand on its head it felt as though near a hot stove, so great was the heat of the scalp. It was quite restless at night, and very thirsty. These were the only symptoms presented. I prescribed six powders of *Arsenicum alb.* 3, to be taken at night, and six powders of *Graphites* 3, to be taken in the morning, with instructions to come back in one week. The next week there was some improvement. The same prescription and instructions were continued. At the third week the patient showed marked improvement.

Partly to experiment, and yet thinking all would be right, I *mixed* the same remedies in about equal proportions and gave instructions to have them taken night and morning, and to return after one week. At the fourth week there was not the slightest improvement from the last prescription. Indeed, the mother stated that the patient ceased to improve after the first dose. I decided that the medicines when mixed did not work as when given separately, and accordingly returned to my first prescription.

Fifth week.—There is a very marked improvement; the head is almost clear of scales and crusts and the child rests

well at night. The mother stated that it showed improvement after the second dose of the last prescription. This time I sent them home without medicines, telling them to come back in two weeks. In a fortnight the head was entirely free from any eruption whatever, and the hair was beginning to grow. Two months later the child had a good coat of hair, and the mother felt happy.

I think that, as there were marked symptoms for both of the remedies given, either of them alone would have effected a cure. Since that time I have never mixed my remedies.

3. THE TREATMENT OF DIABETES BY ARSENIC. BEING A RESUME OF AN INAUGURAL THESIS, BY JEAN-EMILE LONGEVIALLE. PREPARED BY DR. H. P. HOLMES, OF OAK PARK, ILL. The author begins by an introduction in which he states that he has observed the good effects of arsenic in diabetes and is surprised at the difference of opinion among the leading physicians regarding the use of this remedy in that disease. I will endeavor to give the principal features of this study in a concise form.

Though known from the greatest antiquity arsenic was not employed in diabetes until towards the middle of the present century. By turns vaunted and decried by the physicians who have used it arsenic does not yet enjoy the honorable place that it should occupy in the treatment of diabetes, and our design is to show that by it one may obtain, if not the complete cure of the patient, at least a considerable diminution in the proportion of sugar excreted, as well as a positive amelioration of the other pathological symptoms which accompany it.

Experiments clearly prove that arsenic diminishes in very decided proportions the quantity of glucose passed by animals under the influence of arsenical poisoning where the puncture of the floor of the fourth verticle was practiced upon them. Arsenic was also given to diabetics, and the figures given further on clearly demonstrate the result.

In the historical part of the thesis the author states that arsenic was first used in diabetes in 1834 by Berndt, who successfully treated seven diabetic patients with arsenic, opium and emetics. In 1864 Owen Rees, with the arsenical preparations, cured a patient whom the other remedies had not been able to relieve. Trousseau and Pidoux say : We have sometimes prescribed arsenic in diabetes and the results do not seem to be unfavorable. Other authorities

find its action *nil*. Saikowski, in 1866, wishing to decide if the principal location for the production of sugar was in the liver attempted removing that organ from the living animal, but found it was impossible to prolong life after the liver was removed. He finally based his conclusions upon the fact that at a certain stage of arsenical poisoning the sugar disappears from the liver and that organ is found to be in a condition that would be similar to an animal whose liver had been removed. If the glycogenic function be in the liver, then the puncture of the floor of the fourth ventricle, or poisoning by curare should not produce sugar in the blood of animals thus treated by arsenical poisoning.

Saikowski also experimented by puncturing the fourth ventricle in twelve healthy rabbits and in twelve rabbits previously intoxicated with arsenical preparations. The first group all passed urine containing a certain quantity of sugar, while in the second group there was only a slight trace of sugar and showed only a feeble reaction to Trommer's test. For another test ten healthy rabbits received subcutaneous injections of curarine. As soon as the poison began to make the rabbits restless, he applied a ligature to the member above the point of injection and removed the ligature when the period of danger had passed. Then, according to the nature of the case, the injection was repeated. In this manner he was able to keep the rabbits under the influence of curarine for three days. Five of them were submitted to the action of arsenic while the curarine was continued and none of them became diabetic. From these experiments Saikowski believes the liver plays a preëminent role in diabetes.

M. M. Devergie and Foville in a communication say: "A medication which, in the greatest number of cases of diabetes, we dare not say in all, would have for its effect the suppression of sugar in the urine, or of considerably reducing the quantity, would be of incontestable utility. This result we propose to obtain through the use of arsenical medications."

A woman with prurigo of the vulva, finding the usual remedies unsuccessful, consulted M. Devergie, who resorted to arsenic. Some peculiarity led him to examine the patient's urine, where a considerable quantity of sugar was found. The two diseases, prurigo and diabetes, were watched simultaneously, and both steadily improved, and finally disappeared under the use of arsenic. He is thus in favor

of arsenical medication in diabetes, whether there is a skin disease present or not.

M. Foville, Sr., treated a diabetic patient who passed more than 60 grammes of sugar in twenty-four hours. In a few weeks Fowler's solution reduced the daily quantity to 2 or 3 grammes, and this result was maintained after the suspension of the remedy. M. Foville, Jr., writes: "Arsenic is one of the best means of preventing the symptoms of diabetes. \* \* \* Numerous instances where, to our knowledge, it has produced a rapid and durable amelioration leave no doubt in my mind in this regard."

Illustrations going to prove that certain mineral waters known to be beneficial in diabetes derive their curative action from the known proportions of arsenic they contain are given by the author.

Dr. Cyr, in his work, says: "The action of arsenic as a steatogen, and its accumulation in the liver, is perfectly known, and it is infinitely probable that it is on account of that hepatic localization that it may produce glycosuria, although Saikowski has found in his experiments upon animals, that glycogen completely disappears from the liver under the influence of arsenical poisoning. Under that influence it is not a transient mellitus, but a true case of diabetes."

Chapter II. gives the author's experiments upon dogs, rabbits and guinea pigs. The first experiment was made in a non-intoxicated dog. The floor of the fourth ventricle was punctured and death followed the same day. 120 cc. of urine were collected, whose sp. gr. was 1030. Qualitative analysis showed positive traces of sugar, while the quantitative analysis showed the enormous proportion of over nine grammes of sugar to 100 cubic centimeters of urine.

Experiment 2d was made upon a dog considerably under the influence of arsenical intoxication. Aqueous solutions of arsenic were given the dog for five days, and the floor of the fourth ventricle punctured on the sixth day. There was collected 130 cc. of urine with a sp. gr. of 1023.5, containing only the proportion of .134 grammes of sugar to 100 cc. of urine.

Experiment 3d was upon a dog extremely intoxicated with arsenic. The arsenical dosing was kept up for ten days, without any sugar being found in the urine. On the eleventh day the floor of the fourth ventricle was punctured. The urine for the following twenty-four hours measured 80 cc., and contained .228 gr. of glucose, or .285



gr. per 100 cc. of urine. The second day the dog died, and the urine collected showed only .054 gr. of glucose per 100 cc. of urine.

Experiment 4th was on a dog under medium intoxication. The eighth day the floor of the fourth ventricle was punctured, and the urine was found to contain 2.5 gr. per 100 cc. In all these three cases the histological examination of the livers showed numerous fatty granulations in the hepatic cells which forms a test of arsenical poisoning over poisoning by phosphates.

Experiments 5 and 6 were made upon rabbits, and experiments 7 and 8 upon guinea pigs in a similar manner and with similar results.

A second series of experiments were made with the view of ascertaining if arsenic could really produce sugar in the urine. Though none of the animals previously experimented upon had showed traces of sugar, while under the influence of arsenic, three dogs, Nos. 9, 10 and 11, were slowly poisoned with arsenic until death resulted, occupying four days in the first two dogs and nine days in the third. In none of the dogs was the slightest trace of sugar showed in the urine.

Experiments 12 and 13 were upon a rabbit and a guinea pig, in which the arsenical treatment was pushed to a fatal termination in eleven and nine days respectively. In neither was there the slightest trace of sugar found in the urine. These experiments, then, demonstrated to a certainty that the use of arsenic does not produce sugar in the urine.

Chapter III. is devoted to the reports of the treatment of two diabetics, which will be given as briefly as possible.

*Case 1.* Mme. Vve. D—, 68 years, entered the hospital the 6th of September, 1881. Her father died of cerebral hemorrhage. She has no children, and has never been sick excepting from asthma, which she had for a long time, and which disappeared several years ago. For two months she has noticed her mouth being very dry, and the tongue blackish. Digestion is quite good, without constipation. The gums are soft, the skin is dry, and the epidermis of the lower limbs is like an ichthyosis. The urine contains an enormous amount of glucose, which is found by the same means as we employed in the urine of the animals experimented upon. The quantity of urine for twenty-four hours was 4 litres with a sp. gr. of 2037, urea 48 grammes and sugar 300 grammes. The treatment was be-

gun with ten drops of Fowler's solution, and increased from time to time, until on the 26th of October the patient was receiving twenty-five drops in twenty-four hours. At this time the figures were as follows: Urine for twenty-four hours 2.1 litres; urea 10.96 grammes; sugar 123.8—thus showing a decrease in sugar from 300 grammes to 123.8 grammes in forty-eight days. A change was here made to alcohol and the bicarbonate of soda, when the conditions grew worse, until on the 26th of November the urine measured 3.6 litres and sugar 300.65 grammes. Fowler's solution was again employed, and on the 1st of December the urine measured 2.1 litres, and the sugar 137.62 grammes. The suppression of the arsenical treatment again allowed the symptoms to return, and the patient left the hospital.

*Case 2.* Was a lady of 68 years, whose diabetic symptoms dated back about two months. On her entrance into the hospital her urine for twenty-four hours measured 2.5 litres, and the sugar 191.99 grammes. Treatment was begun with Fowler's solution, 10 drops, and increased to 20 drops, with the result that at the end of six days the quantity of urine was one litre, and the sugar 65.2 grammes. The patient began to experience nausea and vomiting, and the treatment had to be suspended.

The author sums up the results of his experiments in "conclusions," of which I will give a synopsis: Arsenic is incapable of producing diabetes—at least of doing so in the conditions under which we have experimented. Arsenic is opposed to the formation of sugar in the economy, if not an insurmountable barrier to it. After the puncture of the floor of the fourth ventricle in a healthy dog he excreted over 9 grammes of sugar to the 100 cc. of urine, while a dog slightly intoxicated with arsenic gave only 2.5 grammes the first day, and 1.9 the second. Two other dogs having absorbed much stronger doses of arsenic gave—one of them 285 grammes the first day, and only .05454 the second day per 100 cc. of urine; while the second one gave .134 grammes.

From these experiments it would seem that arsenic notably diminishes the glycosuria of diabetic patients. This is what is proved by our two patients. In effect one of them passing 191.99 grammes of sugar in twenty-four hours, passed only 65.2 after seven days of treatment with arsenic. The other excreted 300 grammes of sugar daily, and after five weeks treatment with arsenic and without the association of any particular diet the amount fell to 123

and 127 grammes daily. When the remedy was suspended the sugar increased to its former proportions and again decreased to 137 grammes after returning to the arsenical treatment. As to the quantity of urea it was analyzed in our first patient and decreased in its daily quantity from 48 grammes to 10 grammes under the treatment. Concurrently with the diminution of the sugar and urea the quantity of urine lost exactly half its amount. Is it possible to obtain results more satisfactory?

As to the medication we will say that it was Fowler's solution given in doses varying from 10 to 30 drops daily. In one of the patients the very large dose of 30 drops daily was reached in less than a week, and it produced a very rapid amelioration, but the gastro-intestinal revolt compelled us to suspend the medication. The dose should be increased progressively and suspended as soon as digestive troubles supervene.

The author questions if it is the same with arsenic as with many other remedies: the symptoms improve for a while and then persist, although in an attenuated degree, and that some physicians doubt the definite recovery of diabetes. Trosseau attributed the failures of arsenic to the fact that the varieties of glycosuria are still but little known, and hopes that some day we will arrive at an understanding of the indications for this remedy and the patients to whom it is applicable.

Whatever it may be, it is so much more consoling for the physician and patient to possess a weapon which almost always drives the enemy back even though it does not annihilate it, and that as MM. Hardy and Behier say: "When one sees the sugar diminish he may conceive, if not the hope of recovery, at least the hope of seeing the life of the patient prolonged."

## Hospital Notes.

### THE SURGICAL CLINIC.

#### SERVICE OF PROF. SHEARS.

REPORTED BY F. H. HONBERGER, Clerk.

DOUBLE TALIPIS EQUINO VARUS.—*Case 19,234.*—A. C., aged five months. A severe case, in which the soles of the feet look upward and inward, and the plantar surface much contracted. Prof. Shears, considering the severity of the case, advised that both tenotomy and syndesmotomy, as recommended by Parker, be practiced. Accordingly, he divided subcutaneously the tendo-achilles, posterior and anterior tibial tendons, the astragalo-scapoid ligaments and the plantar fascia.

The feet were then forcibly straightened and held in position by plaster casts. Emphasis was placed upon the advisability of operating early, before the cartilages of the tarsal bones had time to ossify, and especially before the child commenced to stand upon the feet; the good results of immediate restoration of the deformed foot, notwithstanding the ancient prejudice against it, the necessity in severe cases of dividing ligaments as well as tendons; the imperative-ness of scrupulous cleanliness if suppuration is to be avoided, and the great value of plaster paris splints in retaining the foot in the desired position.

NOTE.—The result was all that could be desired. Six months later the child was able to stand upon the soles of the feet, wearing a stiff shoe and ankle brace.

NECROSIS OF THE ULNA, RADIUS AND CARPAL BONES. AMPUTATION.—*Case 19,237.*—C. W., aged 62 years. This old man injured his hand three months ago handling wood. It inflamed immediately, and soon attained a large size. Abscesses formed and discharged. One week ago he came to the clinic. The hand was enlarged, the fingers and forearm œdematous, and the whole carpal region invaded with pus. There were four fistulous openings in the palm of the hand, five on the back, and several on the forearm. The styloid process of the ulna protruded. At every point of entrance the probe came in contact with diseased bone.

There was no possibility of saving the hand, but Prof. Shears believed that thorough drainage and elastic compression would reduce the swelling in the forearm and place the patient in better condition for an operation. The openings were enlarged, the cavities drained, firm bandages applied and a nourishing diet ordered. To-day much of the œdema having disappeared, amputation was determined upon. Accordingly all antiseptic precautions having been taken, the arm was amputated at the middle third of the forearm, the modified circular operation being made.

Great difficulty was experienced in controlling the hæmorrhage owing to the fragile character of the arterial walls, which were much modified by disease. Attention was called to the condition of the tissues by the operator, who said that under the old system he should not feel warranted in leaving this case until he had amputated above the elbow, feeling sure that subsequent suppuration would result in ulceration and secondary hæmorrhage, but considering the antiseptic precautions adopted he felt warranted in saying that we would have little or no suppuration, and believed we were not taking so great a risk as might appear to one unfamiliar with antiseptic results.

*Note.* The patient made a good recovery without any complications, and rapidly improved in health.

**VARICOCELE.**—*Case 19238.* James R., aged 24. Spermatic veins in the left side much enlarged, constant sense of weight and uneasiness. Is in constant dread that something serious may result from the enlargement in the scrotum. The veins were tied subcutaneously, using the Keyes' varicocele needle and a silk thread. In one week all soreness had disappeared and the patient was at work as usual.

**BADLY UNITED FRACTURE OF THE THIGH.**—*Case 19,239.* Six months ago this little child now four years of age, fell from a third story window, sustaining a fracture of the clavicle, humerus and femur of the right side. Two days after the thigh was dressed with a plaster of Paris cast, which was not removed for six weeks, when the thigh was found in the condition we now see it. The femur has united at an angle, the deformity being quite apparent. The right femur is one inch shorter than the left. This case illustrates what has been so often emphasized in the lectures on fractures that plaster of Paris, while one of the best materials we have for splints, has also its disad-

vantages. It will perpetuate a deformity as readily as it maintains the normal relation of the parts.

If there is any doubt about the perfect apposition of the fragments, do not apply plaster of Paris. Advice is desired in regard to refracturing the femur in order to obtain a more perfect result. This is not advised. The union is firm, the deformity slight and the amount of shortening not excessive. The probability of obtaining a better result under the existing state of affairs, is not sufficient to warrant the additional risk of an operation. A lift was advised for the shoe.

POTTS' DISEASE OF THE SPINE.—*Case 19,249.*—B. C., aged 5 years. Antero-posterior curvature of the lumbar vertebræ, involving the first, second and third, with slight prominence. Attention was called to the carriage of the patient, chin projecting, shoulders elevated, abdomen protuberant; to the careful manner in which he bent his hips and then his knees, and finally squatted upon the floor when asked to pick up an object placed there. These were of themselves sufficient to make one think of spondylitis even if one were not able to detect the deviation in the spinal column. The little patient was suspended and a plaster cast applied as recommended by Sayre. *Calc. phos.* 6 was prescribed, a generous diet ordered, and the parents advised to keep the child in the open air as much as possible.

ABSCESS SIMULATING MALIGNANT DISEASE.—*Case 19250.*—Mr. B., aged 58 years, was sent to the hospital for an operation for malignant disease of the lower jaw. On first sight he appeared to have a tumor on the lower jaw occupying the space from the symphysis to the angle, and involving the sub-maxillary gland. At several points there were fistulous openings from which a thin, sanious pus was discharging. The swelling appeared about six months ago. Six weeks later his physician lanced it, but little relief was obtained. It has since been lanced in several places with similar results, the enlargement gradually increasing. Upon careful examination a curious condition of affairs was discovered. Two pus cavities existed, one sub-integumental and the other under the muscles and deeper fascia, the overflow from the deeper forming the outer collection. In no instance had the lancing been deep enough to drain the inner cavity, and thus little relief had been obtained. Two incisions were made into the deeper structures; one at the angle of the jaw and one some distance below the chin, and

the entire cavity thoroughly washed out and drained. The patient improved rapidly.

PHYMOSIS, CIRCUMCISION.—*Case 19,258.*—Charley B., aged eleven months. The child is irritable, cries frequently and urinates often. The mother thinks that he cries just before urinating. Examination shows the preputial orifice to be no larger than a pin-head. Circumcision was made in the usual manner and the adherent mucous membrane stripped off the glans. One week later the mother reported the child much better; it sleeps all night, does not cry when it urinates, and is less irritable.

ANCIENT DISLOCATION OF THE HEAD OF THE FEMUR.—*Case 19,259.* I. C., aged six years. When eighteen months of age he fell down stairs. No injury was discovered at the time. Six months later the right leg was noticed to be shorter than the other. He was taken to a physician who prescribed a liniment. The child has no pain and has fair motion at the hip. The right leg is two inches shorter than the left. Upon circumduction the head of the femur can be distinctly felt upon the dorsum of the ilium.

This case illustrates two things—the ease with which serious injuries may be overlooked in children, and the wonderful adaptive powers of the system. Although the head of this bone is sadly out of place, the ligaments are so relaxed that nearly all the movements natural to the joint are preserved, and were it not for the shortened limb the child would suffer no inconvenience. At this late day nothing can be done to restore the bone to its natural position.

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## Clinical Reviews.

A TREATISE ON SURGERY: ITS PRINCIPLES AND PRACTICE. BY TIMOTHY HOLMES. New American from the fifth English edition. Octavo, pp. 1,000. Lea Brothers & Co., Philadelphia.

The present edition of this admirable work has been carefully revised by the editor, T. Pickering Pick, and is now fully up to the times in all that pertains to the subject of surgery. The book is a model of conciseness and clearness, its systematic arrangement enabling the author to compare within a single volume what is often with no more advantage to the reader extended to two or three volumes. Its classifications are judicious and generally to be commended. In the classification of tumors, always a difficult matter, the author adopts one founded upon the histological and anatomical peculiarities of the growths. In the main it is a satisfactory one and much more easy to comprehend than the more elaborate classifications of the German authors, but the separation of the sarcomata from the other connective tissue tumors and of the carcinomata from the other epithelial tissue tumors has we believe, a tendency to confuse the student in regard to the relationship of these growths.

Under the treatment of varicocele, we note that which is so common in English surgical works, no reference is made to the sub-cutaneous ligation of the veins, a plan of treatment which we look upon as more serviceable than any other. Although we have mentioned these few points upon which there is an opportunity for difference of opinion, it is not in disparagement of the book which is one that can be warmly recommended to the student or practitioner as one of the best single volumes on the theory and practice of surgery.

G. F. S.



"PRACTICAL SURGERY," by J. EWING MEARS. Second edition, revised and enlarged. F. A. Davis, publisher.

This little book considers under the head of "Practical Surgery," Surgical Dressings, Bandages, Fractures, Dislocations, Ligature of Arteries and Excision of Bones and Joints. The subjects are treated in a simple, practical manner, the author evidently aiming not so much to mention all the different plans of treatment in vogue as to embody the results of his own experience as a teacher and surgeon. This, while it detracts from its value as a treatise on surgery gives it a directness and positiveness that will commend it to the student who is so often lost in a multiplicity of directions and plans.

G. F. S.

OPHTHALMOLOGY AND OPTHALMOSCOPY for Practitioners and Students of Medicine. By DR. HERMANN SCHMIDT-RIMPLER. Translated from the third German revised edition. Edited by D. B. ST. JOHN ROOSA, M. D., LL. D., of New York. Wm Wood & Co., publishers. 1889.

Another substantial, practical treatise has been given to us from the country where so much practical systematic advance is made in all lines of science. Labor and time seem to be disregarded, if something new or useful can be added to the knowledge of a beloved science.

As the title page indicates, this work is especially adapted to practitioners and students of medicine—and although the specialist does not find all the questions settled which might interest him, he can find a very fair statement of the science of ophthalmology as practiced on the continent up to the present time.

The ophthalmoscopic part of the work is small in proportion to the rest.

A very unusual arrangement is found and no explanation given; ordinarily one expects to take up the superficial parts of a subject, going deeper and deeper as study advances; but in this book the order is reversed and refraction is put first, then follows ophthalmoscopy and the diseases of the fundus; while toward the end of the book come diseases of the external parts, closing with those of the orbit.

The arrangement seems odd, perhaps because unusual, but we are inclined to think a student would be easier led

by beginning with the more simple subjects and parts seen, and gradually passing on to the intra-ocular diseases and the wonders revealed by the ophthalmoscope. However, the subject is all here and in good form. It is not narrowed by sectional boundaries, but is generous enough to include opinions of those who differ from the author.

The relation of the specialist to the general profession is well put by the author. In reference to diseases of the eye in connection with other morbid influences and constitutional anomalies, he says: "Here the general medical education comes into play. Without this foundation there can be, in many cases, no thought of a successful and appropriate treatment of the diseases of the eye. It is to be hoped the time will soon pass in which the public may ask, whether the ophthalmologist is also a physician."

The connection between neuralgia and the errors of refraction, and between diseases of the optic nerves and those of the brain being referred to, he continues—"In the same way that every oculist must possess a sufficient knowledge of the other branches of medicine, so the general practitioner can only make a thoroughly scientific diagnosis of diseases of other organs when he has a certain amount of practice in recognition of diseases of the eye."

The author believes in antisepsis and asepsis in addition to simple cleanliness, evidently taking a middle ground in this day of reaction.

The European treatment is fairly shown, an example of which is, the treatment of specific choroiditis by the injection of the bichloride of mercury.

The subject of glaucoma is well handled, and is one of the most pleasing chapters of the book.

Any work on this subject, no matter how recent, cannot long remain as representative of the times, for almost more than any other department of medicine is ophthalmology advancing rapidly day by day.

Prof. Schmidt-Rimpler has been conscientious in his work—has written from his own experience and observation, and the work will be appreciated by the English-reading public.

Dr. Roosa's work in ophthalmology is too well known in America to need any comment, and his name in connection with this book cannot fail to recommend it to American physicians.

C. G. F.

## Miscellaneous Items.

The Old Hahnemann of Chicago opened its XXXth annual Winter Session on the evening of September 17th with a class of 230 students ready and eager for the work before them. The number of pupils is now larger than ever before and in all the departments, scientific and clinical, the course is moving on grandly.—Prof. King has withdrawn his resignation and is lecturing as usual on Chemistry and Toxicology.—Having returned from Europe, Dr. C. G. Fellows has taken an office at 70 State St., where he will devote himself to the treatment of the diseases of the Eye and Ear.—Prof. Dunn's office, for Diseases of the Throat and Nose, is at the N. W. Cor. of State and Madison Sts.—Those Illinois physicians who have changed their residence during the last year, will please notify the State Board of Health at Springfield at once, so that they may come up right in the Official Register.—Dr. W. D. Gentry, the patient and plucky Concordance man, has removed from Kansas City to Rogers Park, Ill., and our old friend Dr. J. D. Craig has returned to Niles, Mich.—Langlois shows that the *expiration* is especially to be watched during anæsthesia.—Prof. Gee's health is much improved and he is on duty at the college.—Prof. Bailey's *medical* clinic on the Diseases of Women is a decided success, quite unlike the routine lectures that most students hate, and would willingly dispense with.—The Reception at the opening of the college for the winter was the very best of its kind.—Prof. Gilman has adopted a luxurious brougham as a 'hygienic precaution.'—Dr. T. C. Cochrane, '89, died Sept. 30, at Menasha, Wis., of pulmonary abscess.—Prof. Lyon has received his new stock of microscopes, and is actively at work with his sub-classes.—The world moves, for the old University of Pennsylvania has followed the example of the "old Hahnemann," of Chicago, in throwing open her classes to the admission of women.—Prof. Hawkes, chairman of the Bureau of Clinical Medicine, will present a report at the next meeting of the Clinical Society, October 26.

# THE CLINIQUE.

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[No. 11.

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## Original Lectures.

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### *AN OUTLINE OF THE HISTOLOGY OF THE NOSE.*

A LECTURE DELIVERED IN THE HÄHNEMANN HOSPITAL, OF CHICAGO, BY H. N. LYON, M. D., ADJUNCT TO THE CHAIR OF HISTOLOGY AND DEMONSTRATOR OF HISTOLOGY AND MICROSCOPY, ETC.

The nose is designed primarily as the special organ of the sense of smell. Secondly, it affords protection to the lungs by preventing the inhalation of foreign particles or deleterious gases, and by warming the air that passes through it. Lastly, its conjoined action with the organ of taste is necessary in distinguishing the properties of many foods.

The term "nose" is used to designate that portion of the organ of smell which projects beyond the level of the face; while that portion which is contained within the bones of the face is termed the nasal fossæ.

In shape the nose is a triangular pyramid of irregular outline, attached by one of its sides to the face, in the median line and immediately above the superior lip.

Externally it presents the following features: The root or summit, its attachment to the forehead; the base, presenting two elliptical orifices, the nostrils, which are separated from one another by a septum or columna; the dorsum formed by the junction of the sides of the nose; and lastly, the lobe or point of the nose. The margins of the nostrils are thickly studded with short hairs termed vibrissæ.

The nose is composed of the following tissues in order: 1°, Skin; 2°, Areolar connective tissue, containing fat cells and sebaceous glands, 3°, Fascia; 4°, Muscles; 5°, Periosteum and perichondrium; 6°, Bones and cartilages; 7°, Basement connective tissue; 8°, Mucous membrane.

Two bones and two bony processes occur in the nose—the nasal bones and the nasal processes of the superior maxillary.

Five cartilages occur which are articulated to one another and to the bones by connective tissue, and are slightly acted upon by the nasal muscles.

Two cartilages are found in each side of the nose—the superior and the inferior lateral cartilage. The fifth cartilage completes the nasal septum.

The upper lateral cartilages are triangular in shape—one edge is attached to the nasal process of the superior maxillary and nasal bone of each side. Their anterior margins are attached to the cartilaginous septum. Their inferior margins are connected to the corresponding lower lateral cartilages.

The lower lateral cartilages are immediately below the former. They are curved in such a manner that they form both the outer and inner wall of each nostril. In this way they form the tip of the nasal septum.

Between the lower lateral cartilages and the nasal processes of the superior maxillary is a space filled with three or four small sesamoid cartilages.

Below the lower lateral cartilages is a mass of dense cellular tissue.

The cartilage of the septum is triangular in shape. It articulates anteriorly with the nasal bones, the superior lateral cartilages and the recurved portion of the inferior lateral cartilages. Posteriorly it is attached to the perpendicular plate of the ethmoid. Its lower margin is connected to the vomer and the palatine portion of the superior maxillary.

The muscles of the nose are but slightly developed. They are the pyramidalis nasi, levator superioris labii, alaque nasi. The anterior and posterior dilators of the nares, the compressor nasi, and the lesser compressor of the nares and the depressor alæ nasi.

The blood supply of the nose is derived from the facial artery and the superior coronary. The former gives the lateralis nasi artery, the latter the arteria septi nasi. These two supply the septum and the alæ, while the sides and

dorsum of the nose receive their blood supply from the nasal branch of the *ophthalmic* and the *infra-orbital*.

The skin covering the nose is thin, and the sub-dermal connective tissue is very loose. The sebaceous follicles in this locality are very numerous and of large size.

Directly back of the nose are two irregular cavities known as the nasal fossæ. In front they open by the anterior nares; posteriorly they open into the pharynx by the posterior nares. These fossæ are narrower above than below, and are constricted midway between the anterior and posterior openings. From the outer wall of each fossa arise three horizontal plates or tables of bone—the *ossa turbinates*—superior, middle and inferior.

With this review of the anatomy of the nose and nasal fossæ, we will dismiss the grosser part and consider the tissues lining these cavities, in detail.

Lining every crevice of these cavities and extending to the various cavities communicating with the nasal fossæ is a mucous membrane which differs in its functions and arrangement from that in other parts of the body. It is known as the *pituitary* or *Schneiderian* membrane. *Pituitary*, from the Latin *pituitus*—mucous or phlegm; *Schneiderian* from that ancient anatomist *Schneider*, who first showed that the secretion was produced by the mucous membrane and did not come from the brain, as was then believed. This membrane lies directly on the periosteum or perichondrium of the bones and cartilages beneath, to which it is held by areolar connective tissue.

Externally its structure merges into that of the skin at the orifices of the nostrils. Posteriorly it blends into the mucous membrane lining the pharynx. It is traced in continuity through the nasal ducts and lachrymal canals; it is connected with the membrane lining the tympanic cavity and the mastoid cells by means of the eustachian tube; and with the antrum of *Highmore*, and the sphenoidal, frontal, and ethmoidal sinuses.

It is from this intimate relationship which exists between these various cavities that the catarrhal troubles are so hydra-headed. An extension of the inflammation into the frontal sinuses causes an engorgement of the vessels there and the consequent dull headache so often experienced. If it extends to the antrum of *Highmore*, we may get a trouble that we treat, unsuccessfully, as a facial neuralgia. If it extends through the eustachian tube we have tinnitus, vertigo, deafness and a host of other symptoms.

The trouble may extend to the eyes or through the pharynx to the œsophagus and stomach, or to the vocal apparatus and lungs.

The thickness of the mucous membrane varies in different localities, and the vascular supply is also greater in the same regions. This is most marked over the turbinated bones, and the attentive observer is often astonished at the small size of these bones after the soft tissues have been removed. Over the septum the tissue is thick, but its blood supply is not so great.

On the floor of the nasal fossæ it is very thin, as well as where it covers the spongy bones.

This difference in thickness in different localities accounts for the prevalence of polypi and similar hypertrophies in certain localities.

Like all mucous membranes, that of the nose consists of the following structures :

*First*—Loose alveolar tissue.

*Second*—A fibro-vascular layer, included in which are the vessels and nerves, some muscular fibres and lymphatics.

*Third*—The basement membrane.

*Fourth*—A layer of epithelial cells.

Imbedded in this mucous tissue are various glands.

The epithelial layer varies in different localities, according to its functions. At the orifice of the nostril, where it is more exposed to injuries, it is of the ordinary variety, and being chiefly intended for protection, is endowed only with nerves of general sensation. In that region lying below the distribution of the olfactory nerves, and intended chiefly for the passage of the air on its way to the pharynx and trachea the cells are of the columnar type, and are provided with cilia. These cilia are in constant motion, and perform an important office in keeping the walls of the nose free from the dust, etc., which is constantly being inhaled, and which otherwise would lodge there. In the upper part of the nose, or olfactory region, the surface cells are of the columnar type, but of the non-ciliated variety.

These latter cells are rather curious, and repay a careful study. Instead of lying on the basement membrane, as is customary, their base is prolonged into a long tail-like process, which extends to the deep part of the mucous membrane, where it branches, forming a net work with the process from its fellow cells.

Between these cells are others which are supposed to be the terminations of the olfactory nerve. These cells

consist of a nucleated body, having a process at either end. One of these processes reaches to the surface of the mucous membrane, where it ends in a flat expansion; the other runs inward, and is probably connected to a filament from the olfactory nerve. This process is constricted at intervals, giving in an appearance somewhat similar to a number of beads strung on a wire.

Thickly imbedded in the mucous membrane of the nose are branched mucous glands, the ducts of which open on the free surface of the mucous membrane.

These ducts are most numerous at the back part of the nasal fossæ, and become less numerous as they approach the anterior nares. The mucus which they secrete is thicker and more tenacious at the posterior nares than at the anterior. The largest of these glands are situated at the lower and back portion of the septum.

From this distribution of the mucous glands, we see the explanation of the greater amount of mucus which drops into the throat than passes out through the anterior nares. And also we see why the mucus in post-nasal catarrh is more tenacious than that ordinarily passed in coryza.

The corium, or foundation tissue, of that portion of the mucous membrane which covers the turbinated bones is much thicker than in other parts of the nose. It is also less closely held down to the periosteum by bands of connective tissue. For this reason we find hypertrophies more common here.

The blood supply of the nose is very extensive. The blood circulates in vessels lying in the fibro-vascular layer of the mucous membrane. In certain portions, especially the regain of the turbinated bones, the vessels freely anastomose, forming large blood spaces.

When the blood supply is increased, these blood spaces become filled, and as a result of this engorgement the tissue swells up. Cocaine being a constrictor of the blood-vessels will rapidly reduce an acute enlargement. When, however, this condition remains for some time, the enlargement becomes permanent, owing to new material being deposited about the blood vessels. From its liability to become enlarged from the action of the blood, this is known as erectile tissue. That which is situated over the turbinated bones has received the name of corpora cavernosa turbinatæ.



## GYNECOLOGICAL SURGERY.

NOTES FROM PROF. LUDLAM'S CLINIC IN THE  
HAHNEMANN HOSPITAL OF CHICAGO.

CYSTOCELE.—Already since the opening of the winter term four cases of pronounced vaginal cystocele have been presented to the class in this clinic.

September 25, when the first of these patients, *Case 20517*, was brought in, Prof. Ludlam said: This is a lesion of place. It is one of a trinity of troubles that sometimes afflict women who have borne a number of children in rapid succession, and who as a rule are past fifty years of age. It is rarely acute or idiopathic. The two other lesions with which it is almost invariably associated are procidentia uteri and perineal laceration. Given a decided hernia of the bladder in a woman and you will very seldom fail to find the two accompanying lesions, if you know enough to look for them.

There are plenty of cases of uterine prolapse short of extrusion in which the bladder is not seriously displaced, and a tear in the perineum does not always result in cystocele, but a procidentia of the bladder, as in this case on the table, is next to impossible if the uterus has not been forced through a rent in the fourchette and its underlying tissues. Here is a demonstration of the conditions of which I am speaking, and you can all see and verify them. (Fig. 1).

The importance of a clear and practical knowledge of the fact just stated is shown in the history of a private case in which I was consulted only a few days ago. The patient, aged 40, was the mother of three children the youngest of which was four years old. Her last labor was unusually severe and prolonged. The child weighed ten pounds, but the delivery was finally effected without instruments. Her puerperal convalescence was very protracted. When the baby was six months old she was suddenly seized with an attack of frequent and painful urination, with an indescribable feeling of distress in the pubic region and along the course of the ureters, running toward the loins. Her physician visited her almost daily for several weeks, and did the best that he could for her relief with his opiates, diuretics etc., but the attacks came and went as before. No local examination was made or proposed.

This treatment was followed at irregular intervals for about a year, when a physician of our own school of practice was sent for. He treated her for another year upon

symptomatic indications, without ever making or requesting an examination. The result was the same, and the poor woman became discouraged, and abandoned all treatment. When she came to my office she had suffered almost constantly for three and a half years in the manner indicated. I soon found that the bladder was practically upside-down, and outside the body, the uterus half extruded through the vulvar outlet, and the perineum torn to

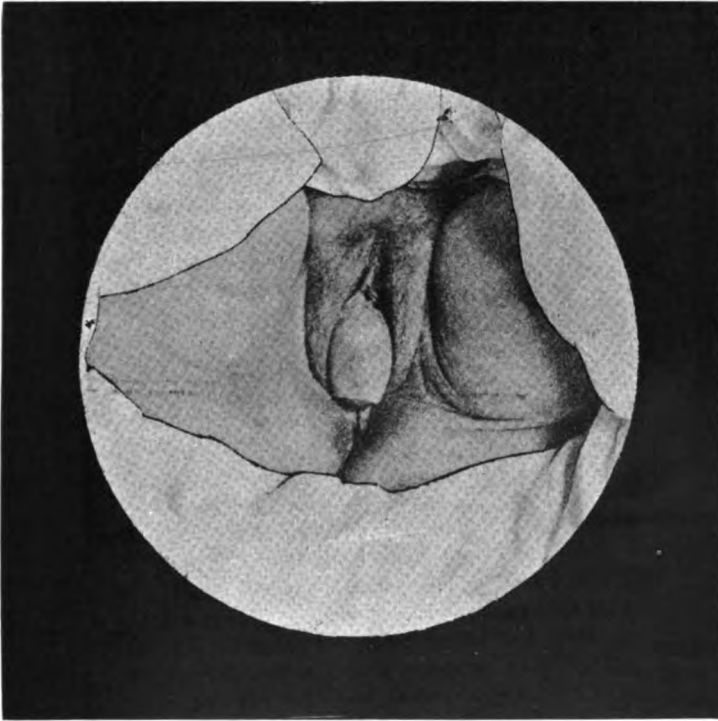


Fig. 1.

the very verge of the anus. Remember, therefore, that cystocele is one of the troubles that never come singly, and do not fail to seek a local cause for chronic vesical mischief.

\* \* \* \* \*

The clinical history of this case has been read in your hearing. There is local dragging, which is relieved at

night by lying down, and increased by standing and walking; frequent desire to urinate, which, if not responded to, finally develops into an impossibility, unless she pushes the bladder upwards, or takes the prone position so that the urine can flow; and the urine itself is strong, alkaline, and offensive. She has kept the parts clean, else there would have been a concurrent vaginitis.

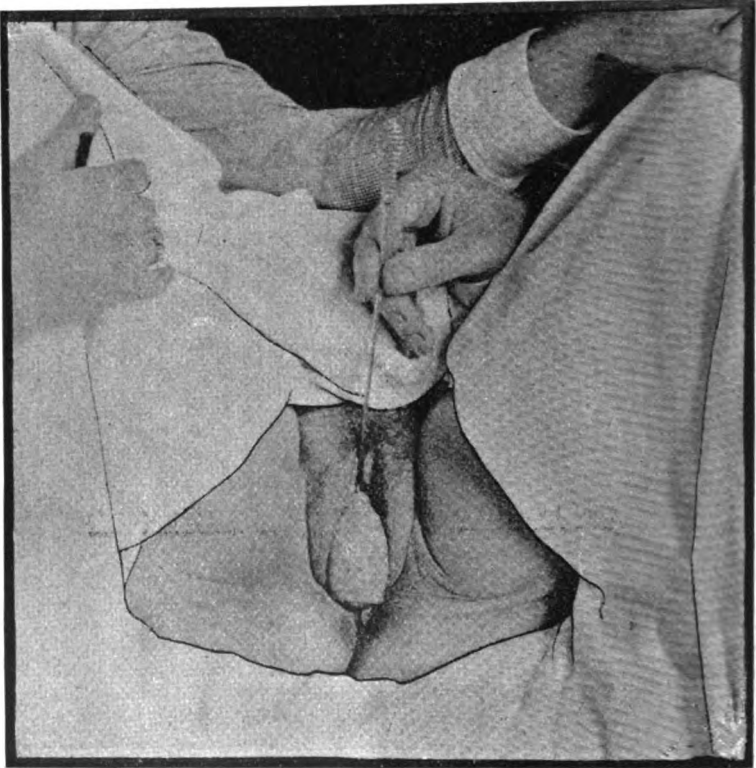


Fig. 2.

The physical signs are easily recognized. To the touch the anterior part of this tumor feels like a cyst, for the urine has been accumulating for some time. Posteriorly I feel the uterus with its firmer texture, and its peculiar form. The size of the tumor varies with the quantity of urine retained, with the patient's bodily position, and with the rapidity and fullness of her respiration. Observe, that

when I tell her to hold her breath and bear down, the whole joint mass is still further protruded. Naturally, the weight of the tumor and the relaxation of the tissues increase the swelling and discomfort when she is forced to stand for any considerable time.

But how can I satisfy you that the anterior part of this tumor is the inverted bladder, and the posterior half the womb in a state of extreme prolapse? I will take this uterine sound, which has been straightened, and pass it into the urethra. If the bladder is "at home," where it should be, you know that its point will pass behind the symphysis pubis, and the handle will drop toward the floor. But you see that the reverse is true, for the point of the instrument has gone toward the lowest part of the tumor, where I can feel it distinctly, while its handle is toward the ceiling. (Fig 2.) \* \* \* \* \*

Now the same instrument when it has been cleaned, will be passed into the orifice at the lower end of the tumor, and we shall see what it will disclose. It enters easily and glides along without obstruction, to the depth of about three inches. I am satisfied that it has passed into the womb as the sound usually does, only in this case the organ is external to the body. (Fig. 3.) \* \* \*

September 30. An anterior colporrhaphy was made in this case before a sub-class of twenty students. The vaginal surface covering the bladder was freshened in an oval form two inches in length, and one and one-half in breadth. Before applying the sutures Prof. L. said this operation often fails because of the strain upon the stitches when they are applied in the old way. But the hidden suture is an effectual safeguard against such a mishap. I shall apply it in this case, and to that end choose a bit of juniper-oil catgut and a fine needle. This, as you see, is run in continuously, bringing the depth of the wound into close contact so as to secure its union and to avoid the strain upon the marginal sutures. In some of these cases two or three layers of these lost sutures may be superimposed, and the ends of the threads cut off. Being of animal texture this buried suture may be left within the wound, and will not need to be removed. These lost sutures are often very useful in closing perineal and peritoneal wounds, and now you will know how to apply them.

The surface stitches will be made with the silkworm-gut, and in passing them great care must be taken not to puncture the bladder, but to bring the edges into close and

careful apposition without so straining the parts as to increase the risk of their cutting their way out. For you must remember that in these plastic operations within the vagina we need to leave the sutures for a longer time than is necessary in other cases. Besides, these surface sutures should be very close together else the lips of the wound would gape, and that would interfere with the primary union which is so desirable and essential in this class of cases.

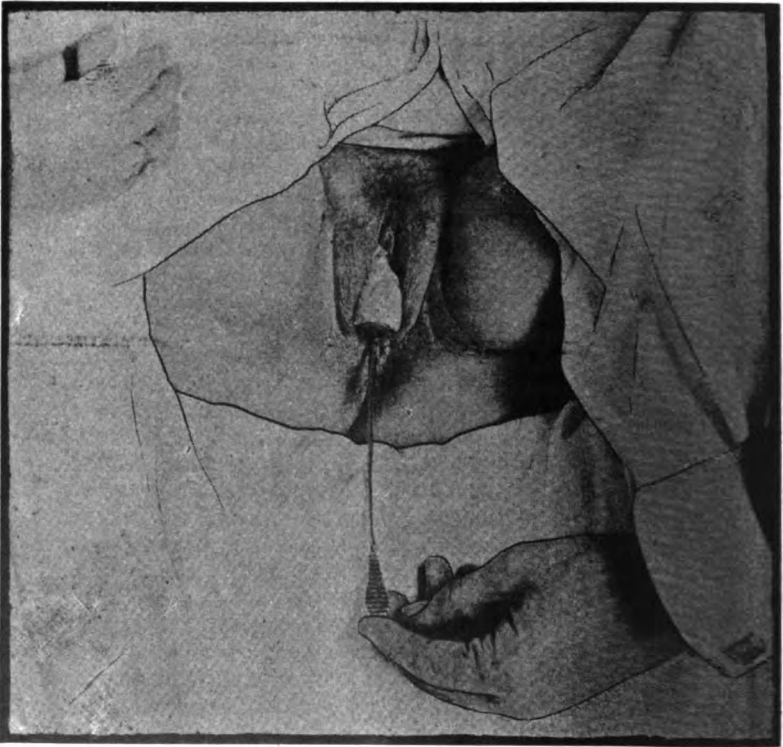


Fig. 3.

October 16. The silkworm stitches were removed at the general clinic, and the union was found to be perfect. It was distinctly stated, however, that the cure was not complete because another operation must be made upon the posterior wall of the vagina and upon the torn perineum.

The patient has promised to submit to such an operation, colpo-perineorrhaphy, in a short time, when she has recuperated.

*Case 20537.* Mrs. —, was brought to the clinic October 9, by our friend Dr. O. Poppe. She is aged 60, is the mother of eleven children, the youngest being 15. For more than three years she has had a protrusion of the bladder, which, although not so large as in Case 20517, is very decided. You will observe that the cystic tumor is covered by thick vaginal mucous membrane, which is thrown into transverse rugæ. Here is the cervix uteri at the lower part of the tumor; and when I lift it a little you can all see that the perineum has been lacerated. I pass the sound into the urethra with the same result as in the former case. It enters the lower part of the tumor behind and goes directly to the fundus uteri. The diagnosis is plain, and the indications for surgical treatment are obvious.

October 15. At a sub-clinic with a class of twenty pupils, an anterior colporrhaphy was carefully made in this case. The vaginal surface covering the bladder anteriorly was removed in a circular form an inch and a half in diameter. The wound was carefully cleansed, and after explaining the different methods of closing such wounds, Prof. L. spoke of the excellent results sometimes obtained from the use of Stolz's method. This consists of running the suture, which should be of strong silk, or of the silkworm-gut, through the margin of the wound after the manner of a purse-string, drawing the surface into close and careful apposition. For this purpose a cervical needle, armed with a silk-worm suture, was taken and passed around below the free margin of the wound, just as a seamstress "gathers" the linen on her needle. It was intended also to make Doléris' operation for the torn perineum, but because of some slight patches of superficial ulceration on the posterior vaginal surface that operation was postponed.

October 30.—This patient has done extremely well. There has been no separation of the edges of the wound, and no sign of suppuration. The suture was easily cut and removed, and the union was found to be perfect.

(In both these cases great pains was taken by the house physician, Dr. Hanna, to prevent a distention of the bladder by the accumulation of urine, and to keep the wound and the affected parts thoroughly clean and aseptic.)

*Case 20538.* Mrs. P., æt. 56, the mother of six children, the youngest being 17, came into the general

women's clinic October 9th. She had a tumor at the vulva, with distressing bladder symptoms, for which she has had no treatment during the last twenty-five years. She is a very hard-working woman, and in all that long time has seldom missed a day from her household service. The vesico-uterine tumor is even more pronounced than in the

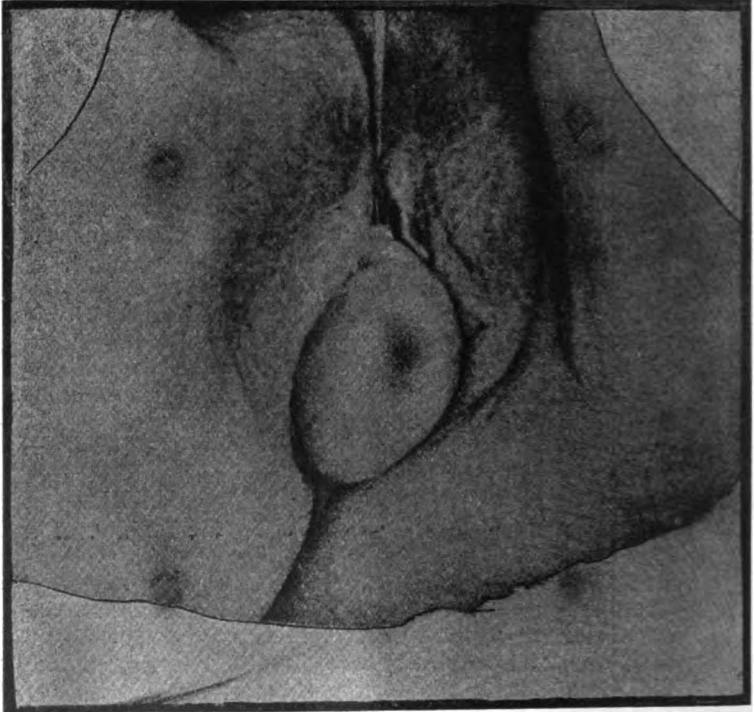


Fig. 4.

other cases (Fig 4), and all the diagnostic points are evident to the class. Here is the inverted bladder, the pro-cident uterus and the perineal laceration. A long breath forces the tumor far out of the vulva, and the vaginal wall is prolapsed with the rest.

The treatment advised for the case was that, for a time at least, she should wear a Halsey's cystocele pessary, which would be sufficient to keep the parts in position, and thus permit her to continue her necessary work.\*

\* For a cut and description of this instrument see Ludlam's *Diseases of Women*, Sixth Edition, page 562.

## Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

OCTOBER MEETING, 1889.

The regular monthly meeting of the Clinical Society was held in the Grand Pacific Hotel, Saturday evening, October 26th. In the absence of the president, Dr. W. S. Gee, Vice President, occupied the chair. The room was crowded with members and medical students who had come to listen to the report of

### *THE BUREAU OF CLINICAL MEDICINE.*

DR. W. J. HAWKES, CHAIRMAN.

I. CLINICAL EVIDENCE AND CLINICAL CASES.—By W. J. HAWKES, M. D.—In these days of revision of the *materia-medica* much is being said against clinical symptoms and clinical evidence. It is proposed by those revising the *materia medica* to eliminate all clinical symptoms therefrom.

All students, whether callow or hoary, acknowledge the cumbersomeness of the work as it is at present and the necessity for a wise and liberal condensation or simplification thereof. But he will be a wise or a bold man who attempts to accomplish this desired end with the expectation of retaining only such symptoms as are reliable and of excluding no valuable ones.

The attempt is being made to have a strictly scientific *materia medica*, one that will be as exact as is any of the exact sciences. This attempt must necessarily be a failure. When we consider the number and varied character of the sources of error in obtaining pure medicinal substances ; in getting correct symptoms in proving ; in making correct diagnoses, and accurate prescriptions, it must be plain that to be exact in a strictly scientific sense is impossible.



Hahnemann said that provings must be made upon healthy persons. There are at the present day none who are perfectly healthy. All are to some extent diseased, owing to the influence of heredity, and of artificial, unhygienic living in the past and in the present ; and all are daily subjected to the deranging influences of artificial and social life. A large majority of the present generation have individual and characteristic disease tendencies. These facts render an absolutely accurate proving impossible. An effort, therefore to make a scientifically exact *materia medica* by eliminating all clinical symptoms and retaining only such as have been positively known to have been produced by drugs will be a harmful failure.

Provers who are in a more or less unhealthy state may fail to observe symptoms which properly belong to the drug, and which would have been observed had the provers been in a perfectly healthy state. On the other hand symptoms may be observed by such prover, owing to his unhealthy condition, which do not properly belong to the drug. When in treating a sick person, a prescription is made in accordance with the then known symptoms of the drug, other symptoms of the patient which are not recognized as belonging to the drug disappear under its action, it is reasonable to presume that these symptoms properly belong to that drug. And when such facts are repeatedly observed by one or more physicians such symptoms become as valuable as those which were in the first place observed in the proving. Some of the most valuable symptoms in my experience, such as are commonly known as "clinical symptoms" are of this character. And any revision of the *materia medica* which excludes such will result in injury to the work, the physician, and humanity.

Much has also been recently said and written against the value of clinical evidence. It is urged that clinical evidence is unreliable; that it is impossible to decide whether the patient recovered through the influence of the drug, or whether it was unaided nature which accomplished the cure. This is doubtless to a great extent true in acute

and so-called self-limited diseases. No one can tell in a case of pneumonia, for instance, whether the patient recovered with or without the aid of medicine, as many recover without such aid. This is true of all other acute diseases. But in those which are chronic this is not the case. Where an individual has been sick for years, where all sorts of measures have been resorted to to bring about recovery, and where nature unaided has herself failed, it is safe to conclude that if recovery now follows promptly a well indicated and carefully selected medicinal agent, such agent was the direct cause of such recovery. And where in any such condition such a result follows it is absolute evidence, and it is clinical evidence, and is as valuable and reliable as any other.

In treating the sick it is the individual and peculiar disease tendencies of each patient that are the best mark for the homœopathic prescription. There are always two classes of causes for sickness. One, and the chief one from a therapeutic stand-point, is this inherited or acquired predisposing tendency in the individual. The other, or exciting cause, is external and common to all. It is chiefly against the former that therapeutic action is efficient. Against the latter, hygiene and sanitary science are the chief weapons.

For example, in intermittent fever: A number of persons enter what is called a malarial district; all will be subject to precisely the same external conditions; eat the same food; sleep in the same house; work at the same employment, and be under precisely the same external influences. One of these will be attacked with a violent intermittent fever, the paroxysm occurring every second day, have a severe chill, high fever, terrific headache, profuse sweat and delirium. The second of these will have a chill every third day, not so violent, not accompanied by so much fever, probably no headache, and in all respects be much less sick than the former; the other will go scot free, and have no chills, no fever, and no sickness whatever.

The inevitable conclusion here must be, that the reason why there was such a difference between the attacks of those who were sick, and that the third was not sick at all, is that there was some peculiar unhealthy condition in the former two which enabled the external and exciting influence to produce the morbid symptoms observed, and that this morbid condition was different in the two attacked, and that it did not exist at all in the one who escaped.

It would be absurd, then, to direct therapeutic treatment for the cure of the two who were sick against the influences which failed to produce sickness in the third, namely, the external or exciting cause. The proper treatment to remove the exciting causes would be hygienic or sanitary. Correct the hygienic condition of the surroundings; remove the cause of the malaria. But this will not make well persons of the two who have been attacked. The predisposing cause, or causes, still exist in them; and should they be again exposed to similar influences they will again become ill. In short, they have not been cured. Now comes in therapeutics proper; only such measures directed against the predisposing causes inherent in these sick persons will remove them; will take away these favorable beds for disease. Then, should they again be exposed to these similar external disease-producing influences they will be in condition to resist them; and like their comrade who was exempt, they will also escape the fever.

Thus it is, for instance, that typhoid fever once established cannot be arrested until it has run its full course. The severity of the case, other things being equal, depends upon the condition of the patient, and not upon the virulence of the poison causing it. The function of medicine in such a case is to so correct this inherent morbid condition so as to enable the patient to resist the external exciting cause. It is not directed against the germs causing the fever, but against the patient's disease tendencies. And the most valuable symptoms indicating the remedial agent are not the symptoms common to typhoid fever. The most

valuable symptoms in such cases are those peculiar to the individual which point toward the predisposing cause.

All that medicine does in such cases is to safely guide the patient through the course of the disease. Medicine acting curatively thus has precisely identical action on the patient's neighbor where it serves as a prophylactic. As a prophylactic it prepares the subject by eradicating or modifying his disease tendencies so that the external cause or germ may find no suitable bed to fructify and grow. In some cases prophylactic action is sufficient to totally prevent an attack of disease. In others it has only had time or power sufficient to partially correct predisposing conditions, and thus modifies the violence of the attack only. Thus it is true that the curative action and the prophylactic action of medicine are identical.

I will report a few cases illustrating my position on the value of clinical evidence :

*Case 1.* R. J. White, aged 40, consulted me October 8, last, being brought to my office by one of the present class, suffering from what seemed to be a dyspeptic condition. The serious part of his ailment was of about four weeks' standing. He was sallow, hollow-eyed, with a despondent, hopeless expression. The history of his case showed that he had in previous years suffered severely from intermittent fever, and had during such attacks taken very large doses of quinine. His recollection of the circumstances of his first attack of ague was that he had suffered first with a violent chill followed by very high fever ; then terrific headaches, some delirium, and later a profuse perspiration which relieved all the other symptoms, and that his attacks came at first in the forenoon. His recollection about his appetite was that he had been extremely fond of salt—he had wanted all his food salted to excess. This symptom exists at the present time ; he still desires a great deal of salt in his food. His symptoms are worse on the alternate days in the forenoon.

Now this patient's condition when attacked with ague years ago surely called for *Natrum mur.*, and it calls for *Natrum mur.* now ; and had he received in his first illness this remedy instead of the blind dosing with quinine he

would not present the sorry spectacle he does to-day. *Natrum mur.* three powders of a 1-m worked a marvelous change in his condition. Two weeks after receiving these three powders he reported that the medicine had worked like a charm; that he was rapidly regaining his health and strength. He certainly presented a very different appearance from that which he did the day he first consulted me.

*Case 2.* H. H. Purcell consulted me October 2. He is a healthy, plump man of 30 years of age, clear complexion, ruddy cheeks, and with no apparent indication of dyspepsia. His complaint was that for the past six months he was in continual mental distress on account of an almost uncontrollable desire to throw himself under locomotives of trains as they passed, or to throw himself from a height. This fear kept him in continual mental distress, so that life had become an absolute burden to him.

The diagnosis here would seem to be suicidal mania, but in his case the much reviled and sneered at "key notes" or "characteristics" enabled me to make a more correct diagnosis. In this manner his most prominent symptoms pointed most unmistakably to *nux vomica* which suggested indigestion. Careful investigation developed a marked case of dyspepsia, although no external sign upon the patient would suggest it. I found that he had been in the habit of eating enormously and with great rapidity, drinking three or four glasses of ice-water with each meal.

The symptoms indicating *nux vomica* and dyspepsia at the same time, were, first, an extreme irritability of temper, which he said was totally foreign to his nature; a bad habit of waking about two o'clock in the morning, and lying awake harrassed by the most despondent thoughts until nearly daylight, when he would fall into a restless, troubled sleep, and be unrefreshed on waking. Obstinate constipation with a frequent urging to the stool with inability to accomplish anything; his food lay like a load on his stomach, and he was troubled with frequent sour belching; stupid dull headache, with a distended feeling of the head that annoyed him greatly. He had in short a perfect picture of *nux vomica*.

I gave him three powders of this remedy  $1 m$  and in a week he reported as being totally relieved of the distressing impulse which had so tortured him ; and that he was improving in every way. His report at the end of the second week, was that all his morbid symptoms had nearly disappeared, and he was indeed a grateful man. He reported again to-day, and although continuous travel on the R. R., with its varied irregularities had somewhat disturbed his digestion, there had been no return of the suicidal impulse, and his remark was that he considered himself well.

This case illustrates the fact which I have so often called attention to, namely, that, other things being equal, the physician who best knows the materia medica is the best diagnostician.

*Case 3.* H. H. L., age 43, came to me Oct. 16, suffering from chronic dyspepsia. He was melancholy, sleepless at night and suffered great distress from stomach indigestion an hour or two after the meal. He was extremely irritable. He had been troubled for 15 years with dyspepsia, gradually increasing in severity so that his life had become a burden to him, and unless he could obtain relief he did not care to live. He also presented a perfect picture of *nux vomica*. I gave him 3 powders of the  $1 M$  with the result that in a week he reported very much improved and hopeful of ultimate recovery.

In each of the above cases I ordered a proper diet, and a careful observance of hygienic laws, which of course were aids in accomplishing the desired results. It cannot be said, however, that the result was altogether, or even in the main, attributable to this, because in each instance hygiene and dieting had been tried repeatedly without satisfactory results.

DISCUSSION.—Dr. R. LUDLAM was pleased that the essayist had touched upon the subject of clinical evidence, for it was at the very foundation of medical progress. Whether such evidence was good or bad depended upon the ability and the honesty of those who testified to the efficacy of any particular method of treatment. Only a small share of this evidence could be received as valid and satisfactory,

for, if the witness was ignorant of the natural history of disease, or if he had never studied the effects of drugs upon the human body in health, his testimony would have to be ruled out of court.

DR. C. W. BREYFOGLE, of San Jose, Cal., at the request of the chair, joined in the discussion.

He expressed his surprise at being called upon as he was not a member of the society, and had not been in active practice for several years. His interest in the work, however, remained the same.

I fully agree with the paper as read, and I fully agree with the remarks by Dr. Ludlam. I believe that the stand taken by our school in regard to clinical evidence has made us a subject of ridicule. Two cases occurring in my practice may be *apropos*.

The first occurred during my residence in Louisville, Ky. Thirteen persons had been poisoned by eating confections prepared in a dirty copper kettle. In a number of them a peculiar symptom was complained of which I have not found recorded in any work. The patients described a feeling as though a stick were on each side of the face, extending from the temporal bone to the jaw, crushing it together.

While this is a symptom obtained from a toxic action of the drug, would I not give cuprum with unbounded confidence if I should ever meet with that particular symptom in practice?

In my residence of seventeen years in California I have been struck by the fact that all persons while becoming acclimated require at some period the administration of sulphur.

Do not all springs differ in constituents? Do not flowers give off different odors? No two things affect the body in precisely the same way, and until they are all analyzed and we know the action of each do we not require clinical evidence?

On the Pacific coast we are isolated and our opportunities for a free interchange of professional ideas are few. I

am glad to meet here others in our profession and to learn that homœopathy is alive in Chicago.

DR. A. K. CRAWFORD.—By way of contrast I wish to disagree with the essayist. As I understand it in acute diseases he takes into account the symptoms peculiar to the patient, and not those which are peculiar to the disease. If he takes this stand most diseases may run their course unchecked. We have, as a rule, remedies capable of meeting these very pathological conditions, and I cannot understand how you can call it homœopathy in prescribing for these episymptoms instead of prescribing for the condition of the disease. We know that bryonia is capable of causing hepatization of the lungs. Arsenic, a vaunted remedy in typhoid fever, has no particular action on Peyer's patches, while the acids have a particular affinity for those parts.

How it is possible to diagnose a disease by the action of the remedy which has been given, even if we can rattle off a thousand symptoms of the drug, passes my comprehension.

DR. DAVISON: I have had a large experience in malarial cases, especially among a class of shiftless Hoosiers. I call them Hoosiers not because they come from Indiana, but because they come from Arkansas, which is worse yet. Let me describe a typical case: The door will open a few inches and a head will be stuck in, to be followed by a long, gaunt body, on receiving an affirmative reply to the question, "Is the doctor in?" These people are tall and sal-low, and give out a peculiar odor—the smell of malaria. They are so shiftless that they never bathe, so my first prescription was to send them down stairs to the bath-house, with an order to the proprietor to put a pound of sal soda in the water. The patient is told that the bath is medicated, and it is. On questioning them, your diagnosis is confirmed, for they tell you they have had "chills and fever," and have been taking quinine and whisky. The bath affords a starting-point, and then the indicated remedy is selected. Sometimes it was given high, again low, and at times



times neither would work. One old man proved particularly obstinate. One day he was in the loft of his shanty when it occurred to him that it was time for him to have a chill. Thinking to ward it off, he started for his quinine bottle, when, his foot catching on a nail, he stumbled and fell through the opening to the floor below. From that time he never had another chill.

Among the various remedies used have been *Lycopodium* and *Natrum mur.* I have used both high and low, and have, in a few instances, even tried Fowler's solution. In old cases, especially where they come from swamps lying along the water, hot water, with the addition of sal soda, is excellent to begin with.

DR. H. P. HOLMES: My experience conflicts with that of Dr. Crawford. I believe it to be the greatest mistake to give a remedy because some one else says it is good in such and such a disease. While *Bryonia* may be the remedy for pneumonia *per se*, it does not follow that it will be the remedy when the disease is influenced by the vital forces of the patient.

DR. J. H. S. JOHNSON: I have sometimes found it possible to clear up an obscure case after the indicated remedy has been administered which I could not diagnose beforehand. For example, a young man came to me recently who presented a perfect picture of *nux vomica*. He had over forty well-marked symptoms of this drug. Apparently it was a case of cirrhosis of the liver. He was put on *nux* for a week, and at the end of that time the symptoms had mostly disappeared, and in their place was a clear picture of syphilis.

DR. HAWKES: In response to the remarks of Dr. Crawford, I will say that he has set up a man of straw and knocked him over as easily as falling off a log. "Other things being equal," which the Dr. apparently failed to hear, although I tried to emphasize that point, means that the man who knows his *materia medica* knows his pathology, his hygiene, and the other concomitant branches.

If the pathological condition is all that we have to deal with, what use have we for more than one remedy for any given disorder? As soon as we find two or more medicines necessary in any one type of disease we are then in the domain of symptomatology. In regard to the selection of the remedy, the peculiarities of the patient is one of the guides, the chief guide, in fact; but we must take into account the disease *per se*, as well as other considerations. We must get the "whole history." Why do we select bryonia in one case of typhoid and baptisia in another, or rhus or arsenic? Because the particular symptoms call for them.

II. MALARIAL CONDITIONS, by W. S. GEE, M. D.—Even at this day of enlightenment and assured superiority of Homœopathic treatment we are occasionally met with the old statement, which has a decided "nutty" flavor, that malaria furnishes an exception to this method of therapeutics.

Surely, the fact must have been overlooked that from the most malarial district of Germany arose this boon to humanity, and no modern discoveries have prevented its vigorous growth.

"Let such teach others who themselves excel,  
And censure freely who have written well."

If Hahnemann was so conversant with the accepted theory regarding malaria, and was so skillful as an Allopathic physician as to reach the highest position offered a member of his profession, was he not wise enough to give trustworthy instruction after such study and increase of knowledge which evolved the successful Homœopathic treatment? Are the modern theories based upon new and positive information so different as to require an advanced treatment? We fear "A little learning is a dangerous thing," or "Much learning hath made thee mad," when we hear embryonic doctors, or even older heads, who never justly tested his method, railing about the senility of Hahnemann and stating that "modern investigations" have made such and such changes necessary?

"Some are bewildered in the maze of schools,  
And some made coxcombs nature meant for fools,  
In search of wit these lose their common sense,  
And then turn critics in their own defense."

We must respect an honest opinion, but not necessarily accept the conclusion before making the most thorough

investigation. We must remember, too, in dealing with our Allopathic friends that

"Men must be taught as if you taught them not,  
And things unknown proposed as things forgot."

But that should not be true of the disciples of Hahnemann, who are supposed to have verified and accepted his statements before adopting Homœopathy.

Each individual has in his constitution a defect "diathesis," "dyscrasia," "chronic miasm"—discount of some sort which limits his ability to resist disease, and slight influences make him sick.

This condition is hereditary or acquired.

We may call it a tendency to take on disease, or a *pre-disposing cause*. This varies in kind and degree even in members of the same family, and in the same individual at different times. He is also subject to prevailing epidemic influences, which act as *exciting causes*. The careful prescriber must recognize both causes in making a proper prescription, even at his first visit. If the patient is robust in appearance, young, usually in perfect health, and has been out hunting in a marshy locality, perhaps while camping out he has been lying on the damp ground without sufficient protection the prognosis is assured, and if great care is taken in making the first prescription, the patient will recover promptly and completely.

Another member of the same family, perhaps, has never been healthy—always sick yet not seriously. Looks prematurely old, emaciated, active brain, and insufficient bodily development—remnants of former illness still lingering, no relish for food, and has discomfort after eating. Family history unfavorable. The degree of fever will have much influence in making the prognosis in this case. Here the first cause must be considered and never overlooked, to secure the best results.

Among the early symptoms of malarial conditions we have a depression of the nervous system with malaise, languor, loss of appetite, functional derangement, later the more pronounced symptoms and fever. The fever is but one symptom, and while it may indicate the severity of the disease, it is not rational to treat it as though it were the cause. He is but a fractional prescriber who resorts to toxic drug effect to depress the temperature, and has not a comprehensive idea of the condition of the patient if by this means he congratulates himself in the thought that he is doing the best for the patient. He is sacrificing the

vitality of the poor victim and inviting serious complications.

Hahnemann taught a better way, and by faithful diligence we may find it true to our full satisfaction.

Many diseases may be prevented and even arrested by using the similar remedy and malarial conditions are not exceptions. Make the diagnosis, but to select the curative remedy study the individual peculiarities of the patient. Hahnemann said very clearly "When the physician knows in each case the obstacles in the way of recovery, and how to remove them, he is prepared to act thoroughly, and to the purpose as a true master of the art of healing."

He very frequently repeats the word "thoroughly" with special desire to impress the full duty of the physician. The removal of the cause is first: Place the patient with surroundings most favorable to his recovery. The open ditches and upturned earth near his home in some instances can be removed, and in all cases we can give attention to the water used for drinking purposes, and give specific directions regarding the frequency and mode of administering the baths.

In treating these conditions it is easiest to generalize and prescribe *a la regular*, but the results should not satisfy any conscientious homeopathic prescriber who wishes to secure the "speedy, gentle, and permanent restitution of health \* \* \* \* \*In the shortest, most reliable, and safest manner according to clearly intelligible reasons." While there are many symptoms common to most patients suffering from malarial conditions, yet the individuality is so marked in each that close observation reveals marked distinctive features.

In Chicago it is an exception when a patient presents the three marked stages of chill, fever, and sweat with true typical severity. One stage is lacking, or is faintly marked, and a decided apyrexia is unusual. The continued fevers are more common, with days of aggravation taking the semblance of a mixed type.

The remittent varies in degree, and uncomplicated, under favorable treatment runs a comparatively mild course. Another form is the "typho-malarial" first described by Woodward in 1876, but rarely the genuine typhoid or enteric fever.

Within the last year there has been a tendency to relapses, with even graver symptoms than in the first attack. Headache has been a pronounced feature in the early stage

—intense frontal headache. Even in the severer forms with prolonged diarrhœa, the putridity has not been so marked, and less delirium has been present than ordinarily accompanying such critical conditions.

*Case.*—Miss D., æt. 20, of slender form, rather poorly nourished, menstruated irregularly or not at all for many months, was found about noon, March 25, 1887, to have a temperature of 105 degrees, and on subsequent days as follows:\*

*Comments :* This was the most remarkable case of typhoid fever which has thus far been presented, so far as I have been able to ascertain from clinical reports and all available sources. Starting with pleurisy, it was not easily recognized, and it is not uncomplimentary to say that all physicians who visited the case in the capacity of a consultation were confused.

One, in the early stage, pronounced it "pleuro-pneumonia." Another, later, because it lacked the diagnostic points of typhoid, called it "old fashioned typhus fever." The real truth was, none of us *knew* until the diarrhœa appeared quite late in the course of it.

The exceptional temperature, higher in the morning, was misleading. The eruption appeared before any distension of abdomen.

The bowels moved one hundred and sixty-six times, as shown by the nurses' record, and hemorrhage occurred thirteen times.

Four times on the 13th day, three times on the 14th day, four times on the 15th day, once on the 16th, and once on the 17th, with the bowel symptoms, there was no longer any doubt as to the diagnosis—*typhus tumultuarius* of Ræue.

\*1st day, temp. 105 deg.; 2d day, 104 deg.; 3d day, 105 1-5 deg.; 4th day, 98 deg. in morning, and 98 2-5 deg. at midnight. At this point there was extensive effusion into the pleura of left side. 5th day, 1 a. m., 98 3-5 deg, and 103 1-5 deg. at 4 p. m.; 6th day, 8 a. m., 101½ deg., and 11 p. m. 99½ deg.; 8th day, 8 a. m., 100 4-5 deg, and 9 p. m. 103 4-5 deg.; 11th day, 2 a. m., 104 1-5 deg., 8 a. m. 103 deg., and 4 p. m. 102½ deg.; 12th day, 2 a. m., 105 deg., 5:10 p. m. 106 deg., and 9 p. m. 101 deg.; 13th day, 8 a. m. 103 4-5 deg., 8 p. m. 102 deg.; 16th day, 1 a. m. 103 1-5 deg., 3 p. m. 99 4-5 deg., and 6 p. m. 102 3-5 deg., pulse 127; 17th day, 9 a. m. 105 deg, 11 a. m. 106 deg, pulse 155, and 11 p. m. 100 deg., pulse 118; 20th day, 4 a. m. 103 2-5 deg., pulse 140; 25th day, 1 a. m. 99 4-5 deg., 3 p. m. 99 4-5 deg., pulse 126; 32d day, 6 a. m. 101 deg., 6 p. m. 98 deg., pulse 118; 34th day, 6 a. m. 98 2-5 deg., 6 p. m. 99½ deg., pulse 100; 49th day, 8 a. m. 98 2-5 deg., 8 p. m. 99 1-5, pulse 84. 56th day, 8 a. m. 98 1-5 deg., pulse 190 (excited), 8 p. m. 98 2-5, pulse 84. The pulse was not below 84 when discharged.

The temp. was  $105^{\circ}$  at the beginning, reached the normal on the 4th day, and was up to  $106^{\circ}$  on the 12th day; also was  $106^{\circ}$  on the 17th day, with the pulse 155, and one hour later 162.

Two faithful trained nurses (and at times three) kept close watch over this patient, and made a close hourly record. Without the aid of these faithful messengers this patient, and very many others, would not now walk the streets of *this* country, we may be sure.

Great aid was obtained from the skillful use of the cold abdominal compress, and the sponge bath. A study of the temperature record will show an unflinching response to its use, even when at the highest point.

It is noticeable that after its use in the early stage of the disease, the pulse was slower as the temperature declined. Later the pulse remained unchanged, or at times possibly, was more rapid after the bath. This condition was the guide for the use of stimulants.

The pulse was rapid for a time after the fever had wholly subsided.

There was acceleration of the pulse from excitement. It was slowest when the patient was sleeping.

Considerable anxiety was occasioned among the nurses and the friends because of the frequent movements of the bowels, but a careful analysis soon quieted them, for soon after the appearance of the diarrhoea the delirium diminished, and no difference was discernable on pulse or temperature to indicate an ill effect from that source.

The routine "regular opium clysters" were so prominent in their minds, much firmness was necessary to prevent interference from that source. One physician who had seen the case with me, telephoned: "Lock up the bowels with opium; that has been my practice for twenty years." This same physician later, said: "If Miss D. gets well, I shall never say again that a patient must die."

In all cases of prolonged illness the matter of diet is of prime importance.

Under ordinary diseases it is not well to compel the patient to take food, but in a condition of great waste and unconsciousness the patient cannot indicate, and the judgment of physician and nurse must act for him.

Graves truthfully said that "a great object of treatment is to prevent patients from dying of starvation."

Flint<sup>1</sup> says: "In the early part of the disease there is

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1. Flint's Practice of Medicine.

generally a repugnance to food, and afterward, owing to the mental state and the condition of the mouth, taste and appetite are wanting. Under the latter circumstances food is to be given, although not desired by the patient, and even when there is a disinclination to take it. \* \* \* The intervals should be two to four hours."

According to Wilson:<sup>2</sup> "It is desirable to give the maximum quantity of proper food that can be assimilated, and not exceed this amount. \* \* \* Food should be administered at intervals of two hours during the day and three during the night."

All agree that milk is best.

Had special attention not been given to diet our patient would never have survived her illness lasting sixty-three days. Some patients who cannot take milk or tire of it, relish "Pure Grape Juice," prepared without salicylic acid or other objectionable drugs.

*Treatment.*—Remedies prescribed according to indications give the best results. A recent case required Hyos. most of the time. The leading symptoms were sleeplessness without apparent cause, debility, mental and general apathy.

*Baptis*—Of course will have a place in many of the low types.

*Gelsemium*—When there is marked nervous tremor and stupidity.

Others are *Ars.*, *Bell.*, *Bry.*, *Calc. C.*, *Syc. Mur. ac.*, *Rhus.*, *Stram.*, *Sul.*

Jenner in "Wilson on Fevers," makes these remarks in reference to the Allopathic treatment: "My experience has impressed on me the conviction that that man will be the most successful in treating typhoid fever who watches its progress, not only with the most skilled and intelligent, but also with the most constant care, and gives *unceasing attention to little things*, and who, when prescribing an active remedy, weighs with the greatest accuracy the good intended to be effected against the evil the prescription may inflict, and then if the possible evil be death, and the probable good short of the saving of life, holds his hand." We may say, however, that when not interrupted by quinine, opium or other drugs, a little medicine of the right kind, and given at the right time, will perform *wonders*.

DISCUSSION.—DR. HAWKES: It is a long time since a better paper has been presented to this Society, either in

2. Wilson on Fevers.

the care shown in its preparation, its literary qualities, or its scientific merit. One point in particular is suggested. In the face of this disagreement among the doctors, if Dr. Gee had been dependent on the diagnosis where would the patient have been those first five or six days? It has been said for years that chills and fever have been the bane of the Homœopathic school. The treatment adopted has been a reproach to the school; the patients have demanded something more powerful, and it is so easy to suppress the trouble with quinine that it has often been given without regard to the consequences.

There has been no literature on Intermittent fever compared with what we have on other diseases until comparatively recently. Now, instead of being the bane, it is the cap-sheaf of Homœopathy. I call to witness our students since 1876, that I welcome such cases to my clinic, as showing what can be done by Homœopathy in chronic and severe diseases. I consider malarial fever a neurosis. Why else should the patient be up and about to-day, and tomorrow unable to leave his bed?

DR. W. H. BURT: I was greatly interested in the case reported, but, like those called in consultation, am not satisfied with the diagnosis. I am inclined to think Dr. Gee did not have a typhoid but a case of tuberculous diarrhœa.

It strikes me that it was a case of suppuration of the bowels, not of a typhoid nature, but, not having seen the case, I am in no position to criticize. As a suggestion to Dr. Hawkes, if he desires to read a work on malarial fevers, which will be of interest to all, Dr. Ludlam's old friend, Dr. I. S. P. Lord, is the author of a work on this subject which has been of very great help to me.

DR. A. K. CRAWFORD: Two or three points in the record show that if it was a case of typhoid it was complicated, and severely complicated, before it was typhoid, if such a condition is possible.

Typhoid alone will not give a temperature of  $106^{\circ}$ . When such a temperature occurs you have something added.



Suppose it takes five days for the disease to develop before the pathological lesion can be determined, then there is no call before that for the administration of a pathological remedy. If it takes twenty-four hours for hepatization to occur, then it is not necessary to give a remedy which is known to produce hepatization before it has developed. But our means of diagnosis are now so perfect that we can usually determine when these pathological conditions take place.

DR. LUDLAM spoke of the significance of the inverted type of the fever as shown by the clinical thermometer in rare cases, and also of the causative relation of the pleurisy in the case reported by Dr. Gee. Every experienced ovariologist and every competent obstetrician knows and appreciates the peculiar liability of peritonitis to be accompanied or followed by pleurisy, and *vice versa*. And, taking the history of this case as given, he would submit that, having begun in the thorax and extended to the abdomen, and being septic in character, with a high temperature, a rapid pulse and a critical diarrhœa, it must have been a septic entero-peritonitis.

DR. GEE. Dr. Burt must have misunderstood if he considers the diagnosis was made at once, for the paper will correct that impression. As regards the "tuberculosis" idea the diathesis of the patient was referred to, but surely this was not the diarrhœa from that source, as the temperature was not so "irregular" and "in tuberculosis diarrhœa is rare, and the abdomen is apt to be flat or even scaphoid," (Wilson) while in this case the tympany was marked.

Would the doctor expect recovery from such a condition, with such a temperature and pulse? Dr. Crawford says typhoid fever does not produce such a temperature unless severe complications are present.

On page 215, "Wilson on Fevers," is noted instances of recovery after a temperature of 106.16°, and one case of 107.825°. Nothing is stated regarding complications, but it is true that all parts of the system are severely taxed and yet not develop what are strictly complications. We have

a right to our honest opinion, nor is it surprising that we do not all agree. No remedy ever produced the *whole* phenomena of typhoid fever or pneumonia, nor is it necessary, to act on such a case curatively. With these pathological conditions the nervous system is disturbed in a way peculiar to the disease. Drugs produce a similar disturbance of the nervous system, and possibly if the proving was carried far enough, as functional troubles may become organic, might produce the organic features of these diseases in the later stages.

Our remedies act upon and through the nervous system as a key opens the doorway to a chamber, and a key fits a lock with its own peculiar combination only, whether the inner chamber be a bank, grocery or a doctor's office. So the remedy acts when the indications are present—the susceptibility of a patient “similar” condition regardless of the disease by name. Diagnosis and prescribing are distinctly separate.

Dr. Ludlam has mentioned an important clinical symptom, but taking the history of the case, the time which elapsed between the disappearance of the pleurisy and the fact too, that in the kindergarten there was a large number of cases of scarlet fever as the result of defective drainage, the ground about the building and street was torn up in correcting the difficulty, it is probable that the peritonitis was not a leading, but an accompanying condition. The rapid pulse was ascribed to a weak condition of the heart, and the patient was obliged to lie much of the time for several weeks, as slight exertion, or a little excitement increased the rapidity of the pulse.

VOLUNTEER CASES.—DR. E. E. GWYNNE brought a patient, a little girl of eight years, before the Society for suggestions in the line of diagnosis and treatment. The case was subjected to an informal examination and will be reported upon at another time.

DR. R. LUDLAM exhibited as a morbid specimen, a suppurating cyst of the ovary, weighing 20 pounds, and en-

veloped in the worst possible adhesions, which he had removed two days before the meeting.

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## CORRESPONDENCE.

*Mr. Editor :*

In the report of the Bureau of Obstetrics, as it appears in the October number of the *Clinique*, I am made to say that "I object to the use of the catheter, because if it should be necessary to practice podalic version, its performance would be very difficult. If we are to interfere at all, why should we do so in advance, for when we deliver the child, the operation in itself will be sufficient to bring contractions." To this has been appended an editorial note giving the experience of Dr. Wielobycki and Dr. Guernsey, in the practice of puncture of the membrane. This, in a measure misrepresents my opinions, and is incorrect as a report of my remarks.

The idea which I meant to convey, and that which I take pains to impress upon the class whenever I lecture on the subject of placenta prævia, is not that I object to this as an operation in general, but that I object to it in certain cases. I believe it to be fairly effective in many instances, and to be recommended in simple cases ; but I do object to its indiscriminate employment. I hasten to make this correction in order that my ideas concerning the operation may not stand before the readers of the *Clinique* in a false light, fearing that it will not only be detrimental to me, but may lead others to a wrong estimate of this, at times, valuable operation.

SHELDON LEAVITT, M. D.

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## Hospital Notes.

### THE NEUROLOGICAL CLINIC.

#### SERVICE OF PROF. FELLOWS.

MYELITIS FROM CONCUSSION OF THE SPINE. — *Case 15294.* — April 29, 1889. Mr. O. C., aged 33. Three and a half months ago he had a fall of about ten feet, striking on his back and being injured in the sacral region. He did not lose consciousness. Paraplegia was soon complete, with entire anæsthesia of the paralyzed parts. Control of the bladder and bowels was lost from the first, and the patient has never been able to void urine without the aid of a catheter. The urine is dark and scanty, and shows some ammoniacal fermentation. Neither has he had a natural movement of the bowels since the fall; sometimes obstinate constipation has existed, for which he has resorted to cathartics. At other times, when there has been a tendency to looseness, he would be utterly unable to control their movement.

A sensation of a tight bandage exists around his hips. The testicles are painful and swollen. (He had gonorrhœa about four years ago.)

There is still a good deal of numbness in the legs. He has improved enough to be able to walk some, but the improvement has apparently been at a standstill for some weeks. In walking he steps mainly upon the heel, and is unable to raise himself on the toes. The knee reflex is slightly exaggerated, but there is no ankle clonus.

We ordered the patient to wear a suspensory bandage and take *causticum*, 3. At the end of a week he reported that he could walk better, and that the testicles were not as swollen. The remedy was continued for some weeks at which time there seemed no prospect of further improvement, and there was, perhaps, some aggravation of a few of the symptoms. *Hypericum* was then prescribed, and some slight improvement was reported. Then *causticum* was again given, but with only slight benefit. Afterward *strych. phos. 2* was prescribed in connection with galvanism for the back and legs. Dr. Hoey, the House Surgeon, who

looked after the detail of this treatment, reported steady improvement up to the time the patient left the clinic.

This is a clear case of concussion of the spine, producing some degree of myelitis, and perhaps some hemorrhage. The hemorrhage however was probably of no great extent, and the damage to the cord has been mostly of an inflammatory nature. The paraplegia, the anæsthesia and the loss of control of the bladder and bowels, point to a lesion of this nature. The somewhat exaggerated knee-reflex shows that the lesion could not have involved this centre as seriously as it did some other parts of the cord. How the reflexes were in the earlier stages of the difficulty we have no means of knowing, as the account of the symptoms that we were able to draw from the patient refers rather to the general symptoms than to those which would differentiate the finer conditions. The state of the patient illustrates, however, what will be found in many cases after such injuries, and the result of the treatment so far as it was carried, shows that the prognosis in these cases is by no means necessarily hopeless. Yet had the lesion in the cord involved to a slightly greater degree the gray matter of the anterior horns the paralysis would undoubtedly have been more permanent, and would have been followed by a more or less complete atrophy of various muscles of the legs, particularly of the gastrocnemii, which are the ones that have suffered the greatest damage. Had it been more complete transversely bed-sores would likely have added their horror to the other symptoms.

ACUTE ANTERIOR POLIOMYELITIS.—*Case 15317.* Florence C., aged six weeks. This child has had no use of her right arm since her birth. If the right arm is raised and let go it falls in a perfectly lifeless manner. The child can, however, grasp a person's finger with her hand, showing that the muscles which supply the hand are not paralyzed. All the muscles about the shoulder are flaccid, and though the shoulder looks fairly well rounded the joint lacks firmness, as if the parts were much relaxed. Later the roundness seemed less developed and the shoulder muscles were

undergoing rapid atrophy. The skin was much colder on the affected shoulder than on the sound shoulder.

The mother reports that the accoucheur had trouble in delivering the child, and that he said he was obliged either to break the arm or do permanent injury to the shoulder. There is now however, no trace of any such accident.

The mother is very positive that there has never been any voluntary motion to this shoulder. We must therefore conclude that this is a rare case, the injury dating from birth if not intra-uterine. And perhaps in the circumstances of birth we shall find the explanation we seek. The labor was evidently difficult and it is not improbable that some undue traction was made on the child's neck to expedite delivery. If so it is possible, not to say probable, that a slight hemorrhage was caused in the corresponding anterior cornua of the cervical region of the spinal cord. This would not only give rise to some paralysis of itself, but might cause sufficient inflammatory action to produce the typical appearance of acute anterior poliomyelitis. Gowers refers to a case reported by Duchenne in which this disease developed at the twelfth day after birth. This case is especially interesting because of its dating from birth.

The improvement in the strength of the hand is quite marked, but the atrophy of the shoulder muscles is evidently becoming more complete. This child will in all probability never be able to lift the paralyzed arm from the side by the voluntary action of the deltoid and other shoulder muscles.

As for the treatment of this case it is not probable that much can be accomplished. Such remedies as *causticum* and *arg. nit.* may be of some service, but it is difficult to judge accurately of their real benefit because the disease is regressive in its action. Warm wrappings should be worn on all the paralyzed parts, and massage and electricity are in the right direction especially with older children.

## Miscellaneous Items.

The Bureau of Diseases of Children, Prof. Leavitt Chairman, will report at the next meeting of the Clinical Society, Nov. 30.—Dr. L. N. Slaughter, '88, has located at 3150 Dearborn St., City, and Dr. Judson T. Webster, '89, at Lyndon, Ill.—Dr. H. P. Holmes has returned to Sycamore, Ill.—Prof. C. Gilbert Wheeler is giving the course on chemistry and toxicology in the old Hahnemann.—Dr. C. G. Fellows has been appointed an adjunct to the chair of diseases of the eye and the ear, and assigned to duty as clinical assistant on the hospital staff.—A Homœopathic Free Dispensary has been opened in Denver, Col.—Dr. Emogene Parkhurst, '81, is off for a two years' sojourn in Europe.—The thanks of the editor of the *CLINIQUE* are due to Dr. A. Claude, for an excellent portrait of that worthy Parisian and his son.—Two more of our old friends, Drs. Edward Bayard and Martin Freligh, of N. Y., have been called hence.—Dr. Burt's *Clinical Index of Diseases*, Gross & Delbridge, publishers, is invaluable.—The Calcutta Hom. Charitable Dispensary has issued its report, No. 5, for 1888-89, showing the number of patients treated during the year to have been 7,609, the daily attendance being 20.84.—Dr. W. F. Robinson sends us a translation from Vulliet, on *Massage in the Diseases of Women*, that will appear in our next issue.—One more No. will close the *tenth* volume of the *CLINIQUE*.—Dr. Chislett's lectures on minor surgery are very satisfactory and popular with the class.—November 12, Prof. Ludlam made another abdominal hysterectomy before a sub-class of fifty senior students and physicians, and the patient is doing well.—During the month of January Prof. Hall will give the class a series of clinical lectures on the Surgery of the Rectum.

# THE CLINIQUE.

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## Original Lectures.

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### *ADENOID VEGETATIONS IN THE NASO-PHARYNX.*

A CLINICAL LECTURE DELIVERED OCTOBER 17, 1889, BY W. A. DUNN, M. D., PROFESSOR OF THE DISEASES OF THE THROAT AND NOSE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

We have for our consideration to-day two very interesting cases, members of the same family, that will nicely illustrate a condition which is but poorly understood by the greater number of general practitioners. I shall therefore delay our regular lecture, which was unfinished at the last hour, and explain to you some of the most instructive points in these cases, while we have them before us.

These children, aged 7 and 9 years, together with a sister who is not here, have for a long time suffered from the symptoms usually attributed to nasal catarrh, and have had much done for them in order to cure them of this much abused disease.

Catarrh is in itself no gentle companion, but when you accuse the poor overburdened disease of being the only *casus belli* within the nose, it is indeed too much. It has been the habit, as you know, to call everything within the nose *catarrh*, to make a few feeble efforts to relieve the condition with the same specific that has failed many times, and then give the patient the gratifying information that "catarrh cannot be cured."



If our professor of gynecology classified everything about the uterus as a simple catarrhal inflammation, and knew nothing of the use of the speculum or the uterine sound; if he treated a uterine fibroid as an endometritis, you would have an almost exact simile of what has been done in these cases, and what is being done in hundreds of such cases over the country every day.

It is truly remarkable that the nose, through which the life-giving oxygen that is so essential an element in the human economy should freely enter, and without a proper supply of which life must depreciate, should have been so long neglected, while every other organ in the body has long since been the common property of the profession. The nose is much like the seas in the olden days, when it was thought that beyond a certain limit all things were monsters and hobgoblins, called in the nose *catarrh*.

These cases will bring to your minds the necessity of thorough study and practical application to this much neglected branch of the profession, that you may be able to distinguish the many things within the nose that are not catarrh, and thereby relieve this much maligned disease of many of its horrors. For a long time these children have been unable to breathe freely through the nose, and as a result they have become more or less confirmed mouth-breathers, with the silly expression that accompanies this pernicious habit. There is a slight discharge from the nose of a more or less muco-purulent nature, while from the post-nasal region a whitish gluey secretion is forced down from behind the soft palate.

You will notice a dullness of the voice as if the sound waves were deadened in the post-nasal region. By anterior rhinoscopy we observe the mucous membrane covering the turbinated bodies to be slightly congested, but there is no enlargement of these bodies encroaching upon the meati as is observed in occlusion of the nose from chronic coryza or hypertrophy of the turbinated bodies. The pharynx is seen to be congested and a moderate enlargement of the tonsils exists, with a marked thickening of the soft palate which causes a slight narrowing of the naso-pharyngeal space.

On account of the narrowing of this space and of the enlarged tonsils, it is quite impossible to obtain a view of the post-nasal region with the rhinoscopic mirror, so that to obtain an idea of the changes that may have taken place in this region, it becomes necessary to make the examination with the index finger. This can be done with but

slight pain to the child if you are careful in the manipulation. As a precaution you should wrap the index finger with a small piece of cloth, such as you see me use as a tongue-napkin. This you may fold into a band about an inch wide and wrap around the finger in such a manner that the first joint is entirely free, as there is no danger of this part of the finger being bitten, while you can have perfect use of it in making the examination. You may use the corner of a thin towel for a finger-shield as well. Do not use the large and inconvenient metal-shield usually sold for that purpose, because it is not only inconvenient, but is much more painful to the child. A shield made of soft rubber is also a very useful instrument.

You should place the child on a high chair, or have him stand in front of you while you place your left arm over his head, with the hand under the chin in such a manner that you can easily hold the head while you insert the finger quickly, but gently, behind the soft palate, being careful to give it the proper curve that you may not injure the pharyngeal wall behind, or make traction on the palate in front. If the finger be moistened in warm water or anointed with pure vaseline, the irritation and pain will be much lessened.

In this case, on introducing the finger, we find, instead of the free and almost smooth naso-pharyngeal arch, a soft, nodular mass, that imparts to the examining finger a sensation not unlike that produced by a mass of dense jelly, which is attached to the arch and posterior wall of the post-nasal space. The upper portion of this space is quite closed by the growth, but in the lower part only the posterior half is filled by it, therefore, there is some space remaining through which the child can breathe, but not without embarrassment.

It often happens that the entire space is perfectly sealed by these growths, in which case the child can no longer obtain breath through the nose. I recall the case of a boy 17 years old who had never been able to breathe through his nose, that his mother could remember. This condition is known as adenoid vegetations, or adenomata of the naso-pharynx, and is the result of hypertrophy of the glandular tissue at the vault of the naso-pharyngeal space. This tissue, first observed by Luschka, in 1869, is known as Luschka's tonsil, and is composed of tissue resembling the pharyngeal tonsil, being made up of lymph cells, conglomerate glands, and blood vessels. Owing to the scanty supply of lymph vessels, however, this kind of tissue is very liable to

take on an hypertrophic metamorphosis of the exuded material within the glandular tissue, hence the very great tendency to a permanent enlargement. This gland as seen in its normal condition is but a slight elevation in the superior arch of the naso-pharyngeal space. It is sometimes filled with crypts, but more frequently is not to be distinguished from the surrounding mucous membrane. The predisposing tendency to this condition has its cause, I believe, in an hereditary tendency, as is shown in these cases before you.

In this family there are three well developed cases, but as to the family history in that line I am unable to state, because such a condition would have been considered an obscure case of catarrh. I have seen this condition in more than two members of the same family a number of times. In this class of cases you observe a very marked tendency to glandular enlargement and an increased liability to catarrhal diseases.

The immediate cause is usually an acute inflammatory condition of this region, which in small children is often mistaken for the so-called "snuffles," or acute coryza. The symptoms in the acute stage are much the same as those resulting from acute coryza, which usually attends it. The nose is occluded as a result of the swelling of the glandular tissue to such an extent as to close up the posterior openings of the nares. The inflammation may implicate the nasal spaces and thereby add to the occlusion, or it may extend to the pharynx and soft palate and increase the closure in that manner. There is more or less mucous secretion at this time, owing to the surrounding catarrhal inflammation, which causes the child to be very uncomfortable. Being unable to breathe through the nose, the child is unable to take its food in the usual manner, which causes it to be very fretful and restless.

This active condition usually subsides in a few days, but it is observed that the breathing is not perfect, while the child snores and is restless during sleep. It soon begins to breathe through the mouth as the result of every slight cold, which in time becomes a confirmed habit.

The nose loses its usual full form and becomes thinned and pinched. The *alæ nasi* become flat from side to side and inactive from lack of use. The chest does not properly develop and may result in the so-called "pigeon breast." The chin becomes habitually drooped, the mouth slightly agape and the eyelids show a lack of vitality, which, with the dullness of hearing and the difficult articulation, the

child soon has the visage and appearance of one demented. Indeed, in many cases the reflex depression is so great that the child may quite lose his acute mental ability if the obstruction is not relieved. As the sound waves are stopped or decreased at the post-nasal space, you will observe a peculiar deadening of the voice with inability to pronounce certain nasal consonants, such as *m*, which takes the sound of *b*, while *n* partakes of the sound of *d*, therefore, man sounds much like "bad," a condition that often exists.

Dr. Robert T. Cooper, of the London Homœopathic Hospital, has observed that stammering may be the result of adenoid vegetations in the naso-pharynx. While such a case has not appeared to me, I can easily appreciate how such a symptom may accompany this condition. In this chronic state there is a tough, gluey, whitish secretion coming down from the post-nasal region, which appears as a tenacious mass when the palate is drawn up. There may be scales of inspissated mucus thrown off by drawing air through the nose, but as a rule this does not occur. There is seldom an offensive odor from the nose, owing to the slight tendency to ulceration of the tissue or dessication of the secretion. There is no anterior nasal discharge, unless the trouble is complicated by acute or chronic nasal catarrh.

You may observe partial loss of hearing, resulting from pressure of the mass on the Eustachian opening, or from extension of inflammation to the tube or the middle ear, causing thickening of the tissue and sinking in of the membrane, or suppurative otitis and destruction of the drum.

Follicular pharyngitis is a very frequent companion of this disease, owing to the irritation resulting from the mouth-breathing, especially during sleep. The mouths of the pharyngeal glands become filled with inspissated mucus, causing retention of the secretion which acts as a foreign body and becomes a point of inflammation with hypertrophy of the glandule. The air entering the larynx without the salutary influence of the nose as to the heat and moisture, may lead to congestion or inflammation of the larynx, or be the remote cause of a more serious disease of the lungs. The appearance of the growths when seen by the rhinoscopic mirror, is that of a dense, smooth glandular cushion, which may be dotted by crypts, or what is more frequently observed, that of a more or less nodular, pinkish tumors projecting from the arch and upper surface of the post-nasal region, and filling most of the space between the nasal openings and the posterior wall.

They may be of a soft and yielding consistence, or of a firm and fibrous nature, which depends on the hyperplastic change in the fibrous interglandular stroma.

The treatment of this disease, if observed during the acute stage, is much the same as that recommended for acute tonsillitis, and if applied early may be of great benefit in avoiding the evil consequences that arise from enlargement of the gland, which is quite sure to follow, if this disease is not removed during this stage. By enforced nasal breathing with a sealed respirator in small children, or in those of maturer reason by inducing them to close the mouth much of the time, will greatly prevent the changes that take place in the post-nasal and nasal region. I believe that the inactivity of the nasal respiratory tract and the lack of normal stimulus that results therefrom, adds much to the thickening and sluggishness of the mucous membrane, and favors the hyperplasia of the glandular elements in this region. Usually the child finds it much easier to breathe through the mouth, so that unless he is induced in some manner to make an effort at nasal breathing he will seldom apply this useful organ for that purpose.

If, however, the condition has already become chronic, the treatment is essentially surgical, as a marked diminution of the tissue is not usually observed after the most careful systemic or local treatment. I do not believe you can reabsorb thoroughly formed hyperplastic tissue any more than you can absorb one of the natural organs of the body, because it is made up of fully developed tissue as much as the tongue or the uvula.

In the transition stage, however, when the tissue is not yet well formed, I believe you may be able to accomplish much by medical treatment.

It has been observed that after the age of puberty the naso-pharyngeal region partakes of the general changes that occur about this period of life, and is often so much enlarged that the growth no longer forms an obstruction to the normal breathway, and the patient is quite relieved of the unpleasant symptoms that have so long existed, and he has truly "outgrown the disease."

It is not to be recommended, however, that such cases be allowed to suffer for a number of years with the hope that nature may come to his relief, and do for him what you may do in a few minutes; besides, it often happens that the change is not equal to the obstruction, and serious conditions may have set in before the desired relief is obtained.

In the acute stage I believe you will always find it associated with an acute catarrhal condition of the nose, and perhaps of the post-nasal region and pharynx, and you will usually be unable to differentiate it from a common case of infantile catarrh, so that the treatment of this stage will be modified by the surrounding and general conditions.

I am not aware that any person has observed the action of remedies on this particular tissue, hence it is very difficult to include an actual specific remedy that is known to produce an inflammatory or hypoplastic action on this gland; but from association with the tonsils, of which it is almost a counterpart, we may readily outline a number of remedies which must have a curative action here.

Belladonna will no doubt be of great service in the early stage of this disease, as well as in the tonsillitis which often accompanies it. The active appearance of the disease with bright red and highly congested throat and post-nasal region; the suffusion of the eyes, which feel enormously swollen; the bright red tongue with the enlarged papillæ; the spasmodic action of the throat with difficulty in swallowing fluids, and the fact that belladonna usually affects the parenchyma of such tissue which so often leads to hyperplastic changes, all suggest this remedy.

We find also the thick, dull speech, and a feeling as if something were in the throat which must be hawked out. Dryness of the pharynx and a narrowed feeling; tightness and oppression of the chest; starting as in a fright from sleep with anxious dreams, and moaning and tossing about are also characteristic symptoms.

As a rule there is a dyscrasia as the remote cause of this class of troubles, so that we must strike at the constitutional taint with some of the usual alterative remedies, such as calc. carb., calc. phos., baryta iodide, or sulphur. In those cases in which the hyperplastic tissue is still in the formative state we may be able to cause a reabsorptive metamorphosis to take place which will quite restore the gland to its normal condition, or at least, to such an extent as to free the respiration from embarrassment, which is the primary object of all treatment.

Prof. Cooper, of London, recommends calc. phos. as being the most perfect specific for adenoid vegetation that we can obtain, and if accompanied by a moderate degree of deafness, enlarged tonsils and the usual constitutional symptoms, this drug will be of great benefit in effecting a cure. It should be continued for some time, as must any remedy of this class.

Calcareo carb. will be indicated in children of a leucopneumatic temperament with a tendency to obesity, which is accompanied by a lack of vitality and muscular tone. There is a marked tendency to glandular enlargement, especially about the neck. A sore, ulcerated condition about the nostrils which have a tendency to bleed in the morning; pain in the throat which may extend to the ears, and a sensation as if the throat were contracted when swallowing; tightness and oppression of the chest, with shortness of the breath on going up stairs; may have frightful dreams and restless sleep followed by great exhaustion in the morning.

Iodium is the remedy in this form of glandular trouble in those cases that are of a markedly scrofulous diathesis. This remedy produces a decided tendency to cellular hypertrophy owing to a perverted ganglionic nervous supply, causing a changed nutrition of the glandular elements. I believe you will find it a valuable remedy in bringing about a better local nutrition and perhaps, a re-absorption of much of the increased tissue. The action of iodium will be much aided by a mild solution of the first potency in glycerine applied directly to the tissue with a cotton carrier after using a spray of boracic acid (grs. v-x, aqua ʒj), in order to clear the surface of the mucus.

Baryta carb. has a marked action on this disease in children when there is an imbecile expression with a lack of mental development. He is slow to learn to talk or read, owing to mental weakness. There is a lack of physical development as well as mental, pointing to the usual dyscrasia which is often the only thing they will inherit in this life.

Every slight cold causes enlargement of the tonsils and the other glandular tissue in this neighborhood. This remedy does much to prevent the return of acute exacerbations as well as to correct the malnutrition from which they arise.

You will find many other remedies of use in the different conditions arising in this disease, among which you should consult aconite and mercurius in the acute condition, and in the chronic form you may find sulphur or conium the most characteristic.

You should bear in mind that this condition as a rule is a local manifestation of a constitutional dyscrasia, and should be treated as such; but that by long continuance the local changes become thoroughly organized tissue, which is no longer amenable to medical treatment, and we must look to surgical means for relief, of which I shall speak to you at my next hour.

## Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

NOVEMBER MEETING, 1889.

The regular monthly meeting of the Clinical Society was held in Parlor 44, of the Grand Pacific Hotel, on Saturday evening, November 30, 1889. In the absence of the President, the Vice-President, Dr. W. S. Gee, occupied the chair. The attendance was the largest of the season, there being 125 members and students present. After the usual routine business, the Society listened to the report of

### *THE BUREAU OF DISEASES OF CHILDREN.*

DR. SHELDON LEAVITT, CHAIRMAN.

I. DIETARY ERRORS IN YOUNG CHILDREN.—BY SHELDON LEAVITT, M. D.—In my clinic at the Hahnemann Hospital, I am frequently confronted by cases over which anxious mothers have greatly worried, wherein the chief, if not the only cause of disturbance, has arisen from improper food and insufficient intervals between meals. Some of these cases would doubtless promptly recover were I to do nothing but institute a correction of these errors. I have never submitted any of them to this form of treatment, but I have thought it advisable to give but little medicine, and have had the pleasure to see them promptly recover, in most instances, from the effects of their mismanagement.

The anxious mother relates a plaintive story, telling how that, for a number of weeks or months, her child, who formerly had been robust and hearty, has lost his appetite, has complained of epigastric pains, has been reduced in flesh, and in her opinion, is on a sure road to inanition.



On making more particular inquiry with respect to the appetite, I am told that the patient has very little desire for food, and that little is for sweetmeats or certain kinds of fruit; that at mealtimes he can scarcely be induced to eat anything, and in the interval between meals, he is always asking for food. As a rule I find such patients have been indulged in their whims, and this information usually proves to be the key that unlocks the mystery which has surrounded the child's health for the specified period.

I am well aware that it is the theory of some, that children, as well as adults, should receive that food, whatever it may be, which they seem to desire. We are told that nature is infallible in her indications, and that it is the duty of parents and physicians to follow her intimations. I am free to say that I do not subscribe to any such dogma, and, from what I have seen with my eyes, and heard with my ears, I deduce an entirely different inference.

To be sure we cannot all agree upon what constitutes proper diet for young children; neither indeed can any of us be sure that a certain regimen will be good for all children; or that it will be equally well fitted to the same child at all times; yet it should be remembered that there are certain articles of food which most practitioners, as well as laymen, have learned from observation, are harmful, not to all, but to the larger number of those who indulge in them.

I shall not attempt to give a complete catalogue of them, but may name a few, such as nuts, candy in great quantity, cake, pie and bananas. I have met a number of children concerning whom I was informed, that on other occasions, physicians had recommended bananas as a wholesome and harmless article of food; and very likely some of you will here protest against my denunciation of this fruit. There is less disagreement, I infer, among physicians concerning the other articles named, inasmuch as I have never learned of their being commended. I do not wish to pose as a banana crank, and still I would much rather be so dubbed than keep silent concerning the ill effects which I have often seen follow the ingestion of this fruit by young children. I shall

be surprised to have you all agree with me. We look **through** different eyes and catch the rays of light at different angles. My friend and colleague, Dr. Gee, discovers medicinal aggravations where I can see nothing of the sort. He looks for them, and lo! they appear. If I were on the alert for them, very likely I should discern them. One man says "I saw," and another, "I saw not." Whose testimony has greater weight with judge and jury? Apply this rule of evidence to my testimony this evening, and notwithstanding the objections which may be raised, the verdict will be for the plaintiff.

"Why," one will say, "I have been feeding my children bananas ever since they were babies, without harmful effect." It is very true that all children are not affected alike, either by bananas or other articles of food, whence has arisen the old adage, "what is food for one is poison for another." It seems peculiarly true of the fruit here spoken of. Children with the various organs in strong functional activity are able to digest and assimilate food which would throw other and feebler children into great distress. Some will bear almost anything we choose to give them, from breast milk up to tooth-picks, but that does not make tooth-picks in general a harmless article of diet. Precisely why bananas should be harmful to many children, I may not be able satisfactorily to explain, although I have my own theories upon the subject. We should not forget that this fruit is picked in an entirely green state, is shipped long distances, and is brought to "ripeness" (an improper use of the term), as it is said, by forcing processes, which at the same time engender decomposition. Degeneration is attended by certain chemical changes which I infer are more or less harmful to all, but the influences of which may be withstood by some. The most baneful effects of improper diet are seen among young children of naturally feeble constitutions. Such, under mismanagement, often work into a state of marasmus, or suffer acute disturbances which prove destructive to their young lives.

When the stomach becomes deranged, it is quite prone

to call for some, or all of the articles of food above named, in preference to others ; and yet I infer from observation that they are then no more likely to agree than when supplied without the manifestation of these special desires. "My child," says the mother, "has no appetite for anything, and indeed has eaten nothing for several days but a little cake and some bananas." And we usually find that this condition of things will continue so long as the dietary management remains unchanged.

Errors in feeding do not arise wholly from mistakes in the selection of food, but also in insufficient intervals between its supply. It is quite essential that the stomach, as well as other organs, have a certain amount of repose. Even the heart, which we say is always busy, has short intervals of rest between contractions, the sum of which, for twenty-four hours, represents a considerable period. Yet many parents do not seem to think that the digestive organs need rest, at any rate we thus infer from the fact that they appear to make a special effort so to supply them with food, that, from early morning till midnight, they shall be kept constantly at work. This is all wrong. The food which is taken into the stomach, should undergo the usual physiological changes therein, and then be passed along into the intestinal canal, with a margin of time left for recuperation before the stomach is again set to work. This is one very important factor in the establishment and maintenance of normal functional activity of this organ. If we have a child under our care possessing weak digestive powers, it may sometimes be advisable, especially when the stomach is unusually irritable, to give very small quantities of simple food at short intervals ; but observation has led me to believe that such practice should be the exception and not the rule. I regard it as far better, under ordinary circumstances, to instruct patient's parents to withhold food from their children during stated intervals, and these of considerable length. Three meals a day may not be as well suited to a certain child as four, or possibly five ; yet, as a general rule, and especially among the class of children to which I

have made particular reference, I believe three meals quite sufficient.

To many members of this society, such observations as I have here indulged myself in, may seem better adapted to students and the laity than to practicing physicians; but my excuse for offering them is found in the neglect which physicians sometimes show, and particularly in the unphysiological instructions which they sometimes give.

DISCUSSION.—DR. A. K. CRAWFORD said that he was thankful to have been called upon first so that he might forestall his good friend Dr. Ludlam in the remark that the essayist had opened up a very *fruitful* subject for discussion. Not only does the fruit question deserve attention, but, as the doctor proceeded with the reading of his paper, there were suggested to his mind some striking points of resemblance between mal-digestion trouble, when at all persistent, and that other more serious marasmic disease called progressive pernicious anæmia. Both, seemingly centralize in the digestive tube, both are attended with inappetency and imperfect assimilation, both have wasting of tissue, and that other important symptom in pernicious anæmia, viz : fever, could be found, usually, he believed, in the class of patients cited by Dr. Leavitt. Therefore he wondered whether there was any relationship between these maladies, or whether the neglect of the one might lead into a pronounced case of the other.

DR. GEE.—I believe we must be governed by the indications. When we find a craving for a particular article of diet that is continuous for several days we should allow the patient to have a small quantity. I believe bananas to be prejudicial, but would not advise the indiscriminate prohibition of their use. We can tell when we have an aggravation from the use of a drug by the fact that the symptoms grow more severe as long as it is given and disappear as soon as its use is discontinued. Or, if new symptoms arise after a drug has been administered and cease as soon as we stop the remedy we can ascribe them to an aggravation.

If a proper food is selected the child should not show

evidences of pain; there should be no colic, or vomiting, and it should fall into a natural sleep after the meal. If the food is not suitable, or is too strong, or too rich, the stools will show that it is not properly digested, or it may cause pain, colic, vomiting, sleeplessness, etc. If the child cries for more food soon after its meals, and the food appears to be properly digested, it is evidence that the food is too weak.

DR. H. N. LYON.—I am very fond of the banana myself, and frequently advise its use by my patients. The fact that it is picked green and “ripened” afterward is nothing against it. All the choice fruits in the market are picked before maturity and are ripened by artificial means. Nature designed the pulp of a fruit as a protection to its seeds during growth and during the period in which they lie latent in the ground before germinating, and also to afford nourishment to the young plant until it has acquired a sufficient vitality to be able to obtain its sustenance from the soil. *Secondly*, the pulp is a direct factor in the transmission of plants from one locality to another. The pulp-forming an agreeable food, the fruit is carried long distances by man, and the seeds being thrown away when the fruit is eaten may, if the soil and climate are suitable, germinate and attain a perfect development in a new locality. Again, the seeds being unaffected by the digestive fluids, are carried from place to place by the birds and deposited with their droppings. When man disregards these provisions of nature and gathers the fruit for the purpose of food alone he can sometimes improve on nature’s methods by adopting methods of his own.

A winter apple, designed by nature to remain on the tree until loosened by the frost, is picked while still hard and is allowed to “mellow” for several months before its richness is developed and it becomes softened.

Oranges and lemons are picked before becoming fully ripe. They are then piled in “stacks” and go through a “sweating” process before being ready for the market.

The choice Bartlett pears which are so prized owe their delicate flavor to the ripening they get in darkened cellars..

Fruit that is allowed to ripen on the tree, or vine, will not keep after it is picked. In a few hours it will become wilted or may even ferment. Fruit ripened artificially has far greater keeping qualities.

We *can* get as fine bananas in Chicago as can be had in the south if we will take the trouble to go after them. A trip through the banana cellars on South Water street in this city will show them to be large and well lighted and kept free from all traces of decaying fruit or filth of any kind.

On the other hand, if one has the courage to investigate the Twelfth street district, in which most of the banana peddlers live he will find a totally different state of affairs. There anything that will furnish the necessary warmth is utilized as a banana cellar. You will find the bananas hung in the living room that may shelter a dozen or twenty people, in cellars in which the water stands half a foot deep and emits a frightful stench from the decaying fruit that is found all about. I have seen more than one outhouse, or dilapidated stable used for the storage of this fruit. If the essayist refers to the banana that is sold on the streets I must endorse his remarks, but if he condemns the fruit *in toto*, I must disagree.

A microscopical examination of a banana ripened with proper care shows the cells to be large and well-filled. Culture fluids inoculated from such fruit show no more colonies of bacteria or other germs than could be obtained from any fruit that was exposed to the atmosphere. With the others the case is different; we find the fruit wilted, the cells appearing shrunken, thus showing a loss of their watery contents, and disease germs are present in enormous quantities.

DR. LEAVITT—Under favorable circumstances the banana might be beneficial, but I refer to the fruit as we get it. In regard to Dr. Gee's remarks I did not refer to infants especially, and we cannot be guided altogether by the rules he has laid down. A flood may not distress at first, yet may do so later, or be otherwise unsuitable.

In reply to Dr. Crawford's remarks I would say that

errors in diet may be a contributing cause of the form of anæmia of which he speaks, but I am hardly prepared to admit that they constitute the chief cause of such severe conditions.

II. MONEY AS A CONTAGION-BEARER. — BY SHELDON LEAVITT, M. D.—In these days when the germ theory of disease is commonly accepted, and when so much is being said about sepsis and anti-sepsis, it may be well for us to turn our attention to sources of possible contagion, which have received little notice. Observation has taught us that certain diseases are easily communicated from one to another, while others, commonly regarded as contagious, require for development more exposure. Among the diseases recognized as most contagious are scarlatina, variola and rubeola.

A child who was sick unto death with the first of these diseases, fondled at times during his illness certain toys which were soon after laid away and not used for years. Subsequently they were taken out of store for the amusement of another child, who, without any known exposure to scarlatina, soon afterwards came down with a violent attack of the disease.

Three young medical students were out for a stroll, and being near a pest-house wherein were confined several patients sick with small-pox, they with characteristic curiosity, applied for admission. This being granted they visited every department. After returning to their homes they washed well and changed their clothing, supposing this to be adequate precaution against conveying to others the contagion. On the same evening one of them wrote a letter to a friend living several hundred miles away, and that friend, soon after receiving the letter, without any known exposure to small-pox, there being none within miles, came down with a sharp attack of the disease. The foregoing are two out of many similar instances in which the contagiousness of these poisons is well exemplified, and they may serve as precautionary lessons to some of the students and young practitioners here present.

Our boards of health and our careful physicians, give explicit directions to the inmates of the houses into which these diseases have found entrance concerning the advisability and manner of disinfection, not only of things which have come in contact with the sick, but also even the drapery, the woodwork and the various ornaments about the sick room. This is all quite proper, and we cannot afford to relax our diligence and punctiliousness in that direction ; but the purpose of this brief paper is to suggest an equal need of strict antisepsis with regard to some things usually overlooked.

When inquiry is made of the parents and friends of those stricken with these contagious diseases, concerning the probability of direct exposure of the affected persons to contagion, we often learn that the source of infection is a mystery. The parents of our patients frequently assert that their children, from one cause or another, have been kept, either by themselves, or have been strictly guarded, so that they have been brought in contact with no outside children for a considerable time. Whence then the disease? Have we good reason to believe that it is sporadic? If not, then there surely are sources of infection which still remain latent. I am satisfied that, in many of these cases, disease germs have entered the house, not through the visits of other children, or the friends of those who have been ill, but through the money which the parents, or the subjects themselves, have had about their person.

It is not at all uncommon to see children sick with these various ailments, fondling money which has been given them by loving parents or friends, as tokens of affection. Indeed, this train of thought has been set up to-day in my mind by just such an occurrence. No one thinks of disinfecting the currency and coins issuing from a sick room ; yet this same coin, which to-day I saw in the hand of my little patient, is afterward paid out and goes into general circulation. In process of time, and perhaps very soon after leaving the hands and mouth of this sick child, it reaches the hand or mouth of a well one, and conveys



to him the deadly germs. During convalescence children love to borrow, not coins only, but bank notes, from their parents for the purpose of piling and counting them, and then this money, fresh from polluted hands, goes on its errand of devastation. Again, stricken with contagious diseases, men carry about their person for some time and load up with microscopic germs, the money contained in their pocket-books, a part of which is paid out by them or for them, even during their illness. Finally, we know that it is not uncommon for friends to lay silver coins on the closed eyelids of those dead from various forms of disease. It is generally true that these same coins are afterward sent running in the common channels of circulation, and probably often reach the mouth of the young child in its innocent play, or the young lady, as she balances herself in a street-car while she prepares to pay her *f. re.*

If surgeons find it necessary thoroughly to wash and disinfect the instruments used about both the well and sick, is it not just as essential that money, thus brought in contact with disease, and especially that of a contagious nature, be treated to similar disinfection before it leaves the sick room to find its way into our homes and out?

DISCUSSION.—DR. FELLOWS:—The paper just read is very suggestive. After scarlatina children are often allowed to leave the sick room too early, and are allowed to go out, or to return to school before the contagion has had time to become exhausted. Until desquamation has entirely ceased, it is possible for that disease to be communicated from one to another. The virus is chiefly found in the scales that are thrown off. I know of one case in which the clothes of the patient were preserved in an air-tight chest for months. They were then worn by other children who shortly afterward came down with the same disease.

In England, in a number of apparently isolated cases, the source of contagion was found to be the milk supplied by a certain dairy.

DR. GEE: Some years ago Dr. Hoyne had several cases

of syphilis in his clinic which were supposed to be due to having carried money in the mouth.

DR. H. N. LVON: This subject has attracted considerable attention from microscopists for several years past. The first paper on this topic was published about eight years ago. In a recent article a French microscopist states that he has found 118 different organisms and fragments of organic and inorganic substances on silver coins. Two germs have been found so constantly on coins that they are supposed to be peculiar to them and to similar articles that are passed from hand to hand.

DR. LEAVITT: I wrote this paper merely as a rebuke to the habit that is so common of carrying money in the mouth.

VOLUNTEER PAPERS.—I. A CASE OF CONGENITAL ANTERIOR POLIOMYELITIS.—Dr. Belle L. Reynolds said that, having been interested in a case reported by Prof. Fellows in the last issue of the *CLINIQUE* (see page 418), she would present a verbal history of a similar case, and had brought the patient hither for the inspection of the Society. This boy is 5 years old, and has been an inmate of the Home of the Friendless for two years. My attention was called to his inability to use his right arm, and on examination I found that it hung limp at his side; he could not raise or use the arm at all, but he could move the fingers, although there was not sufficient strength in them to enable him to grasp anything. The shoulder presented the appearance of a downward dislocation, and the muscles were so atrophied as to leave that arm only about half the size of its fellow. Thinking this condition might be the result of an injury during his babyhood, I sent him to Dr. Shear's clinic to ascertain if he could benefit the child by surgical means; but he thought it a congenital affair, and advised massage and oil-rubbing; the arm to be put in a sling so that he might have a better use of the hand and of the forearm. As this prescription improved his condition somewhat, he was afterward sent to Dr. Trine's institution for the application of massage and the movement cure.

This treatment has now been given him every morning for about seven months, and as you can see, with excellent results. He has not taken any remedies internally. I could learn but little of his history except that his mother, who is also a paralytic, said that the boy's arm "had always been so."

DISCUSSION.—The boy being stripped to the waist, and mounted on a chair in full view of the Members of the Society, Dr. H. B. Fellows examined him carefully, and as he did so remarked :

This case was undoubtedly in its inception a case of *acute anterior poliomyelitis*, and it is remarkable as dating from birth; in this respect being like the case published in the Hospital Notes in the last number of THE CLINIQUE, which case some of you have seen in my clinic at the Hahnemann Hospital.

You will notice that the muscles about the shoulder and upper arm are smaller on the opposite side than on the other. The deltoid muscle, which is most likely to be atrophied in this type of cases, has so far regained its normal development though still smaller than that of the other side, and it is still lacking tone and firmness. Its function is, however, restored sufficiently to enable the boy to lift his arm readily. The upper part of the pectoralis major has not been so fortunate, for it has suffered atrophy. In comparing the motion of the arms when the hand is carried to the opposite shoulder you will observe that the motion of the right hand to the left shoulder lacks the grace and precision with which the left hand is carried to the right shoulder.

This case is remarkable not only for the paralysis dating from birth, according to Dr. Reynold's report, but for so good a recovery taking place so long after the original trouble. The atrophy could never have been so complete as is that case which we have shown at the hospital; in that case there will be very small chance for the deltoid to regain such development as we have here.

What explanation can we find of this? Both cases

date from birth. In the hospital case a difficult labor, and evidently some force applied directly to the arm is in the history. We have no history of the labor in this case, but reasoning from analogy, we may presume as much. If force is applied to the head to deliver the shoulders, it is not improbable that the spinal cord may be so put on the stretch as to injure it, and perhaps produce a slight hemorrhage. If this, even if only capillary, took place in the anterior coruna, it would cause more or less paralysis, more if inflammatory action followed it; and from the proneness of the gray matter of the anterior horn to take on such action, some degree of it would be most likely to follow. Whenever the diseased action was intense enough, the large motor nerve cells would be destroyed, and the corresponding muscles would not only be paralyzed, but would atrophy afterward—there would be no regaining their lost power for them. But if the diseased action was less in degree, not enough to destroy them, but enough to lessen their nutritional vigor, the muscular fibres would not lose their characteristic structure, although their function might be badly damaged and remain so for a long time. If, after all active diseased action has ceased in the spinal centers, these nerve cells are stimulated by massage to the defective muscles, it is quite probable that improvement would take place in the nutrition or both muscles and nerve cells, and with this would come a more or less return of power. In this case the return of power has been remarkably good, and but comparatively few nerve cells could have undergone destruction, just those which innervate the upper part of the pectoralis major.

Another condition which may, perhaps, play a role in some of these cases of paralysis of infants dating from a hard labor is where force is applied directly to the arm, and injuring the nerve, producing a degree of neuritis, or a degeneration of the nerve fibres. These cases might recover completely.

Dr. Ludlam: Would not such cases be accompanied with great pain?

Dr. Fellows: Not necessarily. The pain, in such conditions of the nerves, varies greatly in different cases, varying from a slight degree, or a sense of numbness, to the most atrocious pain,

Injury to the brain itself during birth must be remembered in all cases of paralysis of infants dating from birth. This is not uncommon, and quite a number appear every year in my clinic at the hospital with such a history. These cases show a more decided hemiplegic condition in a part of them, and in others develop into spastic paraplegia. Many cases of athetosis in children will also furnish such a history. An element that I have observed in all these patients, which has seemed to me a patent element in keeping up the useless state of the arm, is the slight disposition the child shows to use it. Often a pseudo-paralysis remains after voluntary motion can take place, because the patient has become so accustomed to using the well arm for everything he wants to do that the other arm is allowed to hang useless. Massage tends to relieve this, as well as to restore a normal nutrition to the parts.

In reply to the question of what remedies are most useful in these cases, I would say, after the acute stage has passed I have found arg. nit., caust. nux vom. and electricity to do best for me; but they ought not to be used to the exclusion of massage.

## 2. TWENTY GYNECOLOGICAL CASES TREATED BY MASSAGE.

Translated and condensed from Vulliet by DR. W. F. ROBINSON. Prof. Vulliet, gynecologist of Geneva, is a firm believer in the value of massage in the treatment of the diseases of women. He does not think that any but physicians should attempt this branch of massage. The following twenty cases were all treated by himself, either in his private clinic or in his general practice. They will serve to show what may be done by massage in this class of affections :

*Case 1.* Madame X, 40 years old, has suffered with her abdomen for eighteen years. She had at that time a peri-

tonitis which left, as is often the case, bands and adhesions between the posterior pelvic wall and the uterus and its adnexæ. She had already applied to the most eminent specialists, who had treated her by means of pessaries. In spite of all possible precautions, she suffered with a feeling of weight in the abdomen and pains about the rectum, and she was often obliged to remain, for days at a time, in bed.

When called to see her, during the winter of 1887, he examined her under chloroform, and found the uterus hypertrophied and retroflected, a maximum degree of retroversion being present. That organ was firmly adherent to the rectum. He could find neither the ovaries nor the tubes, and concluded that these organs were enveloped in false membranes which bound the uterus to the rectum and to the posterior pelvic wall. The uselessness of the treatment by means of pessaries was plainly shown.

Besides massage the only radical treatment was the operation of laparo-hysterrorrhaphy. So severe were her sufferings that the patient would probably have accepted the operation; but fortunately, being guided by his experience in similar cases, Dr. V. was willing to attempt the treatment by means of massage. This was accordingly begun with great caution, on account of the sensitiveness of the parts, and at the end of a week it showed the following results: The uterus was free on the right side, and the right ovary could now be perceived. The uterus could be straightened, so that the angle of retroflexion would disappear. On the two weeks following the same result was produced on the left side; the fundus of the uterus could be raised above the promontory of the sacrum. He then commenced to support the uterus in the intervals between the seances by means of a pessary. The patient herself now commenced to realize the progress that was being made, and after each treatment she declared that she felt lighter. The pressure upon the return which she had felt for a long time entirely disappeared, and although she began the treatment full of doubts and misgivings, she is now full of hope as to the final result.

At the end of a month, the uterus could be brought into the position of normal anteversion and the ovary and tube could be felt on each side, but in proportion as the organ was freed, new adhesions were discovered tending to draw it to one side, so that it would finally tilt over backward when left to itself.

During the fifth week attention was given to freeing the

uterus laterally. Meanwhile the uterus had grown so much smaller, that it could only be grasped with difficulty. At the end of six weeks, it seemed free in all directions, but nevertheless it was not possible to maintain it in the position of anteversion more than twenty-four hours, without the aid of a pessary, for without apparent reason it would fall back into a state of retroversion.

Dr. V. then attempted to massage the uterus while an assistant kneaded the intestines, at the same time pushing them up toward the epigastrium. By this means he succeeded in completely detaching the utero-intestinal bands which had caused it to fall back.

This patient is now perfectly cured and the uterus is in the normal position. The ovaries are freely movable, and by means of the bimanual method they are easily brought to a distance of three or four centimetres from the uterus. She has not been confined to her bed a single day since the treatment began.

*Case 2.* Madam N., æt. 34, very corpulent, has had four normal deliveries, the last of which occurred seven years ago and since which she has never been well. She suffers with leucorrhœa, irregular and profuse menstruation and a feeling of weight in the abdomen. She walks with difficulty. What torments her most is a constant pain in the bladder and a desire to urinate every half hour when she is sitting down and every two hours when sleeping. When standing, the desire is often so urgent that she has not time to go to the vessel, but must pass the urine in this position, so severe is the pain when she attempts to retain it. The thighs are covered with eruptions, caused by the overflowing urine, and she can neither make visits nor receive them on account of this inconvenient desire to urinate, as well as the unpleasant odor which exhales from her.

During the last seven or eight years she has consulted many celebrated physicians, but the relief, when she obtained any, was never more than temporary. She is almost in a condition of despair.

On making an examination Dr. V. found a double laceration of the cervix, with ectropion and endometritis, the uterus being doubled in volume. The bimanual examination is painful in all parts, showing that the pelvic peritoneum is very generally affected. The urine is normal, showing that the inflammation did not affect the vesical mucous membrane. He decided first to operate upon the lacerated cervix, and as soon as the patient had recovered

from that operation, to use massage for the relief of the inflammation which affected the whole pelvis, but especially the pre-uterine region. The operation on the cervix was successfully made, and the leucorrhœa and menstrual troubles ceased, but the difficulty in urinating remained about the same.

For the treatment of this trouble pelvic massage was applied twice a day, and at night the lower part of the abdomen was enveloped in a cloth wrung out in cold water and covered with another cloth so that the heat of the body soon rendered it warm. The massage was performed by one hand on the abdomen, which made a circular rubbing movement, while two fingers of the other hand, introduced into the vagina, supported the veso-vaginal wall. Great care was necessary in the earlier treatments, on account of the sensibility of the parts, but after five or six days, the tolerance of the manipulations was so great that the hands could be moved with the same freedom as could be exercised were the parts healthy. In proportion as the tolerance became established, the urinary troubles disappeared, and at the end of five weeks of this treatment she was entirely cured. Fourteen months afterward, she had remained perfectly cured since.

*Case 3.* Madame C., æt 28, complained of abdominal pelvic and lumbar pains, which were more intense on the left side. She was feeble, incapable of working, walking or even standing for more than a few minutes at a time; had fever in the evening and perspired freely during sleep; had become thin and ate very little, and her abdomen was large. She was always very well up to her second confinement, which occurred two months and a half before. An attack of scarlet fever had declared itself the day after the child was born, and three days later the abdominal pains began. She remained in bed for three weeks. This was all she could tell as to the commencement of her trouble. This was an example of an inflammatory localization in the pelvis, probably as a result of the scarlatina.

The uterus could be felt, bent to the right and fixed, but the adnexæ on the right side did not seem to be affected in any way. On the left side there is a large tumor adjacent to the uterus and extending up into the abdomen, where it reaches the height of the umbilicus, terminating in a sort of ridge. The form of the enlargement is that of an elongated cone lying transversely. Its surface is smooth without inequalities or furrows, and it seems to be situated en-



tirely in the cellular tissue. The peritoneum covering it seems to be healthy, for gentle pressure made upon it does not cause pain. Firm pressure, on the contrary, is painful when made from the vagina or from the abdomen. The diagnosis was latero-posterior parametritis.

The treatment was mixed massage twice a day. The enlargement being supported by the fingers of one hand in the vagina, the other hand performs circular rubbing movements upon the abdomen just over the tumor, with the result that the growth diminished very rapidly in volume. Later in the treatment, efforts were directed to mobilizing the uterus by moving it in different directions. In two weeks' treatment she was entirely cured, the tumefaction having completely disappeared, and the uterus being once more movable as in the normal condition. The patient was seen again six months after the termination of the treatment and up to that time she had not had the slightest return of the trouble.

*Case 4.* Madam N., æt. 36, menstruated at 12 years, the periods being normal; married at 17; three normal confinements and numerous miscarriages. Has always recovered well from the former as well as the latter. The last miscarriage occurred at six weeks, and six days afterward Dr. V. was summoned on account of complications which had set in. He found a severe left-sided parametritis, not sufficient, however, to place the patient's life in danger. As soon as she had recovered from this she left Geneva.

She returned just three years later to consult the doctor, stating that, ever since her illness, she had suffered with intense abdominal pains. She was very much emaciated, and her features bore, in a marked degree, the expression which chronic disease of the genital organs leaves upon the female countenance. She suffered greatly with hysteria and general nervousness.

The vagina and the cervix were normal; the uterus was small, hard, strongly anteflected, and bent over to the right. Pressure is so painful in the left hypogastrium that a thorough examination cannot be made. The periods are normal as far as quantity and duration are concerned, but they are accompanied by an exacerbation of the pains, which begins three days before, and lasts until a day or a day and a half after the appearance of the flow.

On making an examination under chloroform the left parametrium was found to be hard and contracted, and the left ovary adherent to the left cornua. On the right side

the ovary was nearer to the uterus than normal, and displaced backward. The diagnosis was an old parametritis on the left side, with old pelvic peritonitis on both sides, and catarrhal endometritis.

Daily massage; looking to the absorption of the old exudations and the liberation of the uterus and the ovaries. In twenty treatments the organs had entirely resumed their normal condition; the exudation had disappeared, and the ovaries and the uterus were free and in their normal positions. General massage and the Swedish gymnastics were then ordered to strengthen the muscles and improve the general health. Thirteen months later this patient was seen again, and she declared that her health had been perfect ever since.

*Case 5.* Madame M, 37 years old, first menstruated at 19 and married at 27; has had three normal labors and two miscarriages. Since her last confinement, which occurred three years ago, she has suffered with pain in the back and drawing pains in the lower abdomen. Fifteen months ago she noticed that the uterus was descending. She soon became *enceinte*, but, as the pregnancy advanced, the prolapse increased, and finally the labor came on at six months. Since that time the prolapse has continued to develop more and more.

An attempt was made to relieve the trouble by pessaries, but they only caused her suffering, and had to be removed. During the whole winter she suffered with pelvic pains and troubles with micturition. She is thin and anæmic. All the organs, save those of the urogenital system, are in their normal condition.

On palpation the uterus is not found in its proper position, and the whole lower portion of the abdomen is painful, especially the supra-pubic region.

The uterus, capped by the vagina, emerges from the vulva, its cavity measuring eighteen centimetres. Thus there is present, at the same time, both prolapse and hypertrophy of the womb.

After being replaced the uterus remained bent at an angle laterally and to the left. It had very little mobility, and when an effort was made to raise it, the patient complained of pain in the left side. The sound would penetrate only to the point where the angular flexion occurred. The culs-de-sacs were free. The left ovary was prolapsed into the Douglas pouch. The doctor thought that the angular flexion resulted from the fact that the fundus of the

uterus was bound down by adhesions, so that when the cervix was pressed upward and backward that organ could not do otherwise than bend upon itself. This also explained why the pessaries caused pain and were always expelled.

Here then was a case where massage was indicated, not only as a means of cure, but also to render possible the employment of the pessaries. For eight days massage was applied daily, in order to liberate the uterus. The procedure consisted in inserting two fingers under the fundus and pushing the organ in different directions in order to stretch and rupture the adhesions. The uterus was now more mobile and could be elevated more easily and with less pain. The pessary caused no more pain, and was not expelled. A few days later the womb could be returned to its normal position; the sound showed that the angle of flexion had disappeared and that the cavity only extended nine centimetres.

The treatment for the prolapsus, consisting of the elevation of the uterus, along with the massage and Swedish gymnastics, was now begun. After a few days the pessary could be removed without the womb descending, even when the patient coughed. She was now allowed to go a day, walking and working as she had formerly been accustomed to do, the result being that the uterus descended a little and became retroverted. The pessary was therefore replaced and the treatment continued.

Eight days later the pessary was again removed, the treatment stopped, and the patient discharged, she being told to return again in a week, which, however, she did not do. She was therefore sought at her house, and she stated that she had not come back, because she considered herself cured. An examination revealed the fact, that, although the uterus had not descended, it had again become retroverted, and the pessary was replaced and the patient directed to return. Ten days later all treatment was stopped, the womb retaining its position perfectly. Ten months later the patient declared that she remained absolutely free from her trouble.

*Case 6.* Madam de H., German of 32 years, had endometritis with double ovaro-salpingitis and hysteria. Castration had already been proposed in this case. For twenty-six days the treatment consisted of intra-uterine irrigation, the use of the tampon, and massage of the adnexæ. Her health, both general and local, was com-

pletely restored. She was seen again fourteen months later and the cure was maintained.

*Case 7.* Madam de R., Swiss, æt. 33.

*Diagnosis.* Had a laceration of the cervix and endometritis with left-sided parametritis. She complained of pains in the left leg and difficulty in walking. The operation of trachelorrhaphy cured the endometritis, but the parametritis and the pains remained. After fifteen seances with massage they completely disappeared. This woman was seen again, fourteen months afterward, in excellent health.

*Case 8.* Mm. F., French, 49 years of age, had chronic specific endometritis and ovaro-salpingitis. Intra-uterine irrigation and the application of a tampon twice a week with massage every day, cured the case in two weeks.

*Case 9.* Mrs. D., American, æt. 40 years, had double laceration of the cervix, rupture of the perineum, double ovaritis and retroversion. After a month's application of pelvic massage, the symptoms of ovaritis disappeared entirely. Trachelorrhaphy was then performed and the wound healed by the first intention. The massage was now resumed for two weeks, combined with elevation of the uterus and Swedish gymnastics. Complete restoration to the normal condition followed, the uterus being mobile and inclined forward.

*Case 10.* Mm. B., Swiss, 37 years old, with a vesico-vaginal fistula, permanent retroflexion and posterior utero-pelvic adhesions. The fistula was first closed by an operation. Ten days later massage was begun for the liberation of the uterus, bound down as it was, by the posterior adhesions. A month later the patient left the clinic cured, the uterus being maintained in its normal position by means of a pessary.

(To be continued.)

## Miscellaneous Items.

There are over 1,600 students in attendance upon the medical colleges of Chicago this winter.—Dr. E. Lippencott, of Memphis, was chosen president of the Southern Hom. Med. Association, at its last meeting.—Prof. Hall is visiting California.—Prof. Hoyne has just given a brilliant social reception to 800 of his friends.—Gossip to the contrary, Prof. Vilas is still a bachelor; ditto Bros. Laning and Bailey.—*Apropos* of this item, Hills, 70 State St., has a galactagogue, nutrolactis, that never fails.—Letters concerning the examination for resident physician and two externes, should be addressed to the Children's Hom. Hospital, 914 N. Broad St., Philadelphia.—Dr. M. M. Eaton, of Cincinnati, died Oct. 21st, of ulceration of the stomach, in his 50th year.—The Medical Library Association, of Chicago, which is not a month old, has already raised \$10,000 in money toward its proposed club and library for physicians and students of all schools.—Prof. Gilman will report for the bureau of Clinical Hygiene at the next meeting of the Clinical Society, Dec. 28.—The article illustrating the value of Brandt's method of uterine massage contained in this issue of the CLINIQUE, will surely interest our readers.—The Committee of Arrangements for the International Hom. Congress, Dr. Richard Hughes, Permanent Secretary, is hard at work preparing for its Fourth Quinquennial Session in 1891.—Martigny, in the *Revue Homœopathique Belge* for July, confirms the experience of Hopmann, Hack, Fraenkel and Semon, that the surgical removal of nasal polypi has resulted in Graves' disease, and also cites the authority of Dr. Duquesne, that the same thing has supervened the extraction of certain teeth from the superior maxilla.—In a Woman's Hospital, recently established in London, all the doctors are women.—The Helmuth House Reports, third series, beautifully printed and illustrated, are the envy of local surgeons everywhere.—Dr. E. M. Hale desires that medical information concerning any species of the *Cactaceæ* should be sent him before June 1, 1890.—Once more we can truthfully say that college matters are going on grandly; the clinics are full and so are the classés, and the teachers are prompt, pains-taking, enthusiastic and harmonious.

## VALEDICTORY FOR 1889.

This issue closes the Tenth Volume of *THE CLINIQUE*, and it is fitting to remind our readers of what this publication has given them during the past decade. Its pages have now furnished :

Of Original Lectures, chiefly clinical.....	149
Papers presented to the Clinical Society.....	524
Number of Clinical Cases reported.....	1,653
Number of pages of Hospital Notes.....	361

Although it has not been padded with the controversial matter which always has a vanishing value, its yearly vintage has yielded almost one-third more pages than were promised its subscribers. It has had no place for intellectual trifling, for therapeutical illusions, for those gong-phrases which may mean something or nothing, nor for empty agitation of any kind. It took the initiative in reporting and preserving the clinical fruits of our Hospital, and the papers and discussions before the Clinical Society, and it has not for a moment turned from, or trifled with, that important trust. The output is a work of nearly 5,000 pages that will stand for the credit of the school from which it has emanated, of the teachers who have voiced its printed lectures (and many more of the same sort), and of the pupils who have been privileged to listen to those lectures and to study the cases upon which they were founded. It is already, and will continue to be, a work for reference by those busy physicians who like to know and to feel assured that the men who furnished the experience that has been recorded therein are not only competent and capable, but are honest and earnest as well.

Our sincere thanks are tendered to all those friends who have kindly sustained us in this undertaking, and who have spoken so many good words in our behalf. They will be glad to learn by the accompanying Prospectus that our yearly volume is to be enlarged and improved.

This change has been rendered necessary by the increased number of clinics that are given in the Hospital, there now being *seventeen*, instead of seven regular clinics each week, which was the number given when this publication was begun; and because of the growing interest in the good work that is being done by the Clinical Society.

Ten years' experience on the old tack has abundantly shown that the CLINIQUE, which is not and never pretended to be merely a medical journal, meets a need and fills a niche that no other publication in our school of practice does.

The general form and style, as well as the date of its issue, will remain as before, and those who have already furnished us their clinical contributions are earnestly requested to continue their favors in the future. The management will remain the same, and whoever is in arrears is kindly requested to forward his dues to the Business Manager, Dr. E. S. Bailey, 3034 Michigan Ave., Chicago.

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